An Exploration of Partners' Perspectives on Adversity and Challenge

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THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY REASONS.

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Dedication

I would like to dedicate any future benefit of this work to the late Gerry Neanon, University of Portsmouth. Gerry said, "Yes" to recruiting me to a Psychology Degree in 1976 and remained my friend and mentor until his death from Motor Neurone Disease at the age of 70. I know he would have been happy and proud of my achievements, thank-you Gerry.

Declaration

I Angela Bradding, the author of this portfolio hereby grant powers of discretion to the City University London librarians to allow this thesis to be copied in whole or part without further reference.

Introduction to the Portfolio

This portfolio comprises the final component of my Professional Doctorate in Counselling Psychology. It also represents the end of a long, convoluted, and at times difficult journey. The main focus for the portfolio is that of partners, specifically middle-aged partners, like me, who have experienced significant challenges in life by being embroiled in their partner's adversity.

The portfolio is divided into four sections as follows: **Section A** provides an overview and rationale for the focus on middle-aged partners living with adversity. **Section B** presents my primary research which explores the 'lived experience' of partners of problem drinkers. **Section C** presents a case study of a middle-aged female client whose partner died as a result of a degenerative neurological illness. Finally, **Section D** comprises my publishable paper, drawn from the research, which focuses on the 'dry' stages of the women's journey.

Along the way the portfolio also includes personal reflection (in italics) on the processes, motivations and influences in its evolution, with the research component providing potential applications to counselling psychology practice.

All names of participants, clients, and their respective family members, and any potentially identifying information has been changed in order to protect their confidentially.

There are painful paradoxes inescapably present in intimate couple relationships … "a relationship at once calling for the most adult and mature behaviours, and calling forth most primitive and childish ones" (Ryle, 1979: 149).

Section A: Overview to the Portfolio

*At its heart this portfolio concerns the potential benefits to middle-aged partners, like me. As a psychology undergraduate in 1976 I remember being bored, almost repelled by the psychology of aging; certainly thoughts of being middle-aged held little relevance. However, more recently I revisited Erikson's dynamic life-span approach and reflected on my middle-aged return to study. I viewed this as a partial resolution to Erikson's (1902-1994) 'mature-adulthood crisis', between 'generativity' and 'stagnation'. Erikson (1969) noted that change *is possible at all ages. His work is therefore optimistic rather than pessimistic and presents us with a psychology of health rather than self-destruction. I had been searching for an antidote to increasing feelings of treading-water and sought an 'adventure' (Willig, 2001) into hope and optimism.*

At this point I had already seen my husband have a heart attack and emergency bi-pass surgery whilst on holiday in Italy, and had helped him wrestle with on-going health problems on our return home. Throughout these experiences I had made heart-rending comparisons between myself and my mother who had not been given a second chance; sadly my father had died of a heart attack at 55. I felt quite isolated. My mother had recently died from an aggressive brain tumour and I didn't want to reveal the extent of my grief and trauma to my partner. It all got too much and I descended into anxiety and despair. Happily, through my own tenacity, and the support of my husband, family, friends, and my insightful GP who told me, "life is not a rehearsal Angela", I surfaced with renewed vigour. I vowed to live in the present and to minimise the 'magical thinking' that told me something terrible would happen if I voiced my fears. I now inhabit a place from which I enjoy the 'good' times, whilst appreciating 'bad' times can't always be avoided.

So, all things considered, I entered my doctoral adventure with enthusiasm, feelings of autonomy, and a desire to communicate my belief in the potential for positive change and happiness at any stage in life.

Overview to Section B: Research Thesis

The majority of the literature on alcoholism and drink problems focuses exclusively on the individual drinker. This research directly acknowledges that such problems affect the lives of significant others in the drinkers' world, especially a partner, making it highly relevant to both individual and couples counselling. Hence, my focus on partners aims to give them a 'louder voice'. I interviewed ten female partners who were, at the time of interviews, living

with their male problem drinkers, and analysed their 'lived experience' using Interpretative Phenomenological Analysis (IPA). The narratives strongly suggested a journey, and six superordinate themes highlighted the complex, dynamic evolution of the women's interpretations. The journey took us from pre-drink problem days, into the *'thick of it'*, and eventually into *'navigating new relationships'* for nine out the ten women, whilst Ruby's husband continues to drink heavily.

My choice of partners of problem drinkers was partly driven by my experiences of seeing two significant family members, both partnered, struggling to keep their excessive drinking from damaging those around them. On this basis I joined my local Al-Anon group as both an affected 'significant other' and as a researcher; for ethical reasons I made this explicit on my first visit. I was welcomed and supported by the group and am grateful for the insight that this membership afforded, which aided my interpretations, but cannot be explicitly discussed outside of the group. For the purposes of transparency however, I own to having reservations about some of the key messages of Al-Anon, particularly putting one's trust in God (as the individual envisages God); this does not sit entirely comfortably with my beliefs in personal agency. I do however appreciate that this is my perspective, and that others view things very differently, as we see in the research.

Overview to Section C: Casework

The client study in Section C presents my person-centred counselling with 'Diana', a woman in somewhat similar, but also very different circumstances to the women who took part in the research component. She, like them, had made a commitment (to Ron) as an intimate partner when they were both teenagers, but had no idea of the terrible adversity that was to follow twenty years later. Diana was to find herself living with a partner who became seriously ill and eventually died in the local hospice.

Ron had died a year before our person-centred counselling began and Diana appeared to be struggling to make sense of her losses and regain motivation for investing in herself, and the living (Worden, 2001). Diana, unlike my participants, had no opportunity to surface into a new relationship. This case study reveals something of Diana's attempt to continue her relationship with Ron from 'beyond the grave' and the consequences this has for her and her three children.

For the most part Diana appeared to have very little expectation for the future, and believed her *"useful"* life would be over when her children had grown up and left home. This client study explores some of Diana's journey as she faces life without Ron. It reveals something

of Diana's grief, shock, anger and powerlessness at having her relationship cut short by events, which were totally beyond her control. It also tells of trauma and Diana's difficulties in gaining sufficient strength to carry on.

Overview to Section D: Publishable Paper

The last section of the portfolio presents a potentially publishable paper for the journal, *Addiction Research and Theory* (see Appendix 15 for particular publication requirements). The paper focuses on the last two superordinate themes in the 'dry' stages of the women's journeys. Namely: *'Resurfacing reservedly'* and *'navigating new relationships'*. The rationale for this choice is two-fold: Firstly, within the scant literature focusing on partners of problem drinkers, consideration of partners who 'survive' beyond their partner's 'rock bottom' is even more scant. Secondly, such scarcity may mean that counselling psychologists or alcohol-specific support organisations rely on their own assumptions, or impoverished empirical support, which might incline them towards believing that a partner's problems are over once drinking has stopped. The current research shows a much more ambiguous picture of these 'dry' stages such that many of the partners were left wondering 'where they were' with their *'new Dr Jekyll'*.

Finally, as preparation for this portfolio I leave you the reader with the Serenity Prayer (also used in AA and Al-Anon meetings), which has been an important 'mantra' to me throughout my doctoral journey and beyond.

The Serenity Prayer

(God) give me the serenity,
To accept the things I cannot change;
The courage to change the things I can;
And the wisdom to know the difference.

Section B: Research Component

Appealing to 'Dr Jekyll' whilst faced with 'Mr Hyde': An Interpretative Phenomenological Analysis (IPA) of the 'lived experience' of ten middle-aged female partners living with male problem drinkers

Abstract

This study sought to explore, analyse and interpret the lived experience of partners of problem drinkers (PPDs) such that it may make considered therapeutic recommendations for this potentially vulnerable group of individuals. Ten middle-aged female partners of male problem drinkers were interviewed in semi-structured interviews. Accounts were analysed using Interpretative Phenomenological Analysis (IPA). Nine of the ten women were living with a 'dry' problem drinker at the time of the interview, only Ruby remained with Ray who continued to drink heavily. The resultant narratives strongly evoked a 'journey'; entitled, *'drinker's path as partner's adversity and challenge'*. Six superordinate themes (and their associated subthemes) were located along the journey. Namely: *'Life before the drink problem'; 'a creeping onset'; 'in the thick of it'; 'rock bottom'; 'resurfacing reservedly'; 'navigating new relationships'*. The themes describe and present many complex, dynamic, and multi-faceted processes of understanding and change along the journey. The themes are further discussed and synthesized in order to provide responsive platforms for therapeutic endeavour which is mindful of the PPDs need to maintain both their relationship and their personal well-being.

Chapter One: Introduction

1.0 Overview

This research was designed to explore the 'lived experiences' of partners of problem drinkers (PPD) given that this is both an under-researched area and one which holds relevance for clinical practice, particularly counselling psychology. Accordingly, this introduction presents a critical literature review consisting of a range of qualitative and quantitative empirical evidence and competing ideologies pertinent to the experiences of partners of problem drinkers (PPD).

The Alcohol Drugs and Family Research Group (notably Copello and Orford, 2002; Copello, Templeton and Velleman, 2006) have documented how a range of alcohol misuse may affect a wide range of aspects of family life and/or relationships with partners. Specifically: rituals and celebrations, roles, routines, communication, social life, finances and, aggression and violence. This introduction critically reviews the evidence for these potential influences on problem drinking, alongside evaluating a number of major factors which might mediate the lived experience of PPD. These factors include age, gender, personality characteristics, social background, religion, cultural beliefs and metacognitions, and the various characteristics of the problem drinker including his/her 'stage' in the drinkers' path.

Interpretative Phenomenological Analysis (IPA) was chosen as the most suitable methodology with which to analyse the participants' stories as this qualitative approach explicitly acknowledges a vital role for the researcher's subjectivity; referred to as a 'double hermeneutic' (see Chapter Two). The researcher embraces IPA as an opportunity to utilize the multiple aspects of her subjectivity (personal, professional and academic) in exploring the phenomenon of living with a problem drinker. IPA's inclusion of subjectivity validates this researcher's decision to review a diverse range of theory and empirical evidence in order to enhance her ability to 'interrogate' the interview data.

Specifically, the current study seeks to explore, analyse, and interpret the lived experience of partners of problem drinkers such that it may make considered recommendations for this potentially vulnerable group of individuals. Consequently, a primary aim is to review the major therapeutic perspectives and interventions related to the prevention and treatment of alcohol problems within family contexts. With these aims in mind, the introduction is structured to inform the reader about what is currently known about the lives of PPDs, and

to highlight areas of interest and concern for counselling psychologists. This involves drawing upon a sometimes disparate range of sources and methodologies and attempting to 'marry' the work of clinical practitioners with mainstream psychological domains: See Section 1.4 which explores the question of helping a PPD with their partner or as an individual in their own right and Section 1.5 which reviews theoretical perspectives on PPDs and represents a unique amalgamation of existing literature. Later sections of the introduction raise additional relevant issues such as 'being middle-aged' (Section 1.6) as is the case here, and finally a critical appraisal of the role PPDs may fulfil in helping their partner overcome his drink problem (Section 1.7), which many PPDs consider an important part of their role as an intimate 'concerned other'.

This introduction starts by reviewing the literature concerning definitions of problem drinking (Section 1.1). The current research argues the case for a personal definition as opposed to definitions derived from a priori measures such as units of alcohol consumed. This argument is based on the need for a definition which is consistent with the participants' 'lived experience', and useful for practitioners in their work with individual clients (and potentially their partners).

1.1 Defining Problem Drinking

The issues of language and definition are central to providing an appropriate context both for research and therapeutic endeavours. In this case the definition needs to be consistent with a qualitative methodology, specifically IPA with its emphasis on phenomenological experience, and the work of counselling psychologists who are often involved with helping individuals, couples and families affected by problem drinking. Nelson and Quintana (2005) for example, emphasise the role of qualitative research in establishing clinical relevance in contrast to quantitative research in which operational definitions are predetermined by researchers. Similarly, Smith and Eatough (2006: 327) highlight the use of IPA for exploring issues of "significant consequence for the participant [which are] frequently transformative, often about identity and a sense of self"; again pre-existing definitions would mask such aspects of individuality.

The word alcoholism is closely associated with a model of drinking which views this problem as a 'disease'. The self-help organisation Alcoholics Anonymous (AA) and its co-organisations Al-Anon and Al-Ateen rely heavily upon the disease model. This view has advantages in that it offers family members a justification for someone's excessive drinking by viewing it as out of their control, not the family member's fault or done out of choice. However, despite the diagnostic clarity of the terms alcoholism or alcohol dependence (e.g. DSM-V, APA, 2013; ICD-10, 2004) with their potential for absolving 'concerned others' from responsibility, these terms are firmly embedded in the domain of 'negative' psychology and pathology. This reduces the opportunity for 'normalising' and reframing of symptoms within a more everyday context. Using such diagnostic categories therefore conflicts with the aims of positive psychology (Seligman, 1990, 2002, 2003, 2009; Seligman and Csikszentmihalyi, 2000) which seeks to non-pathologise descriptors of human experience (e.g. Lopez, Edwards, Teramoto, Prosser, LaRue, Vehinge and Ulven, 2006; Lopez, Magyar, Petersen, Ryder, Krieshok, O'Byrne, Licchtenberg, and Fry, 2007; Seligman, Steen, Park and Peterson, 2005; Peterson and Seligman, 2004; Snyder, Rand and Sigmon, 2005; Linley and Joseph, 2003 Linley, Joseph and Boniwell, 2003). The normalising of life with a problem drinker is most clearly seen within the assumptions and theoretical underpinning of the stress and coping perspective and is discussed in Section 1.5.2. Further, much existing literature imposes a pre-determined definition of alcoholism on participants potentially masking personal views and beliefs (e.g. Cranford, Floyd, Schulenberg and Zucker, 2011; Halford et al., 1999; McCrady, Epstein, Cook, Jensen and Hildebrant, 2009; Nolen-Hoeksema, Wong, Fizgerald and Zucker, 2006).

The ICD-10 (2004: 79) for example, refers to Alcohol Dependence as,

> *'A cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug/alcohol, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state'.*

These defining phenomena suggest a drinkers' path which becomes increasingly solitary and inward looking, and by implication increasingly difficult for partners, family members, and friends. Specifically, living with an alcohol dependent individual is likely to precipitate various physical, behavioural and psychological responses, some which might be broadly positive and supportive, others 'negative' and critical. Whilst a diagnosis of alcoholism provides a clear idea of what should be done in terms of treatment that is aiming for pure abstinence, it does not provide any explicit meaning or guidance for those living with an alcoholic before cessation of drinking. Perhaps most seriously for counselling psychology, Velleman and Orford (1999) argue that despite some potential advantages of the disease model, it has not been successful in illuminating the origins of alcohol problems, nor led to advances in treatment or prevention. One of the aims of this research is to provide 'signposts' to counselling psychologists derived from the 'lived experience' of the current participants, which may serve to enhance their evidenced-based practice.

Many researchers now choose to use the term 'problem drinking' which uses the participants' individual frames of reference; which is consistent with the respectful and non-judgemental, person-centred milieu in which this research is couched. Velleman's (1992: 3) definition of problem drinking is argued here to be particularly valuable:

> "If someone's drinking causes problems for him or her, or for someone else, in any area of their lives, then that drinking is problematic".

Velleman's (1992) definition resonates with that used by Casswell, Quan, and Huckle (2011) who explored the well-being and health status of 3,068 individuals who lived with heavy drinkers. Participants were asked to consider, from their own perspectives, whether they believed they shared their lives with a problem drinker. Three-quarters of these respondents were partners of problem drinkers, and reported the heaviest exposure to potentially damaging impact. Similarly, Hutchinson (1999) found that it was the *perceived* fear and risk of harm from a partner's drinking, not the amount per se that was important.

Velleman's (1992) definition also allows the problem drinker to be at any stage of their drinking path as long as problem drinking is an important consideration for the participant. It

also acknowledges observations that partners are often unaware of the extent, quantity, or frequency of their partners drinking habits (Maslin, Velleman and Copello, 1998). Enquiries about such potentially unknown variables might elicit unreliable, invalid and/or potentially misleading data, or even precipitate stress and distress for the participant who might feel they *should* know. Similarly, it respects the participants' choices of disclosure and respects their decisions to remain living with their problem drinker. On a pragmatic level many studies, particularly in the USA, adopt differing definitions which makes direct comparisons difficult. To embrace a participant definition facilitates the making of contrasts and comparisons across research endeavours, which reduce such difficulties.

A review by Templeton, Velleman, and Russell (2010) recognised the value of personal, experiential definitions of drinking problems for those who are negatively affected by the alcohol misuse of an adult partner. They argue that more precise medical or objective definitions are of far less importance in research, such as here, where no intervention is provided. Further, Nelson and Quintana (2005) note the importance of qualitative research in exploring the socio-cultural contexts and psychological mediation of participants' experiences, which in turn can be used to therapeutic effect with clients. Similarly, Ponterotto, Kuriakose and Granovskaya (2013) make the point that in most qualitative research, as here, the participants are actively involved in the process of defining and elucidating variables of interest resulting in rich personal data of relevance to applied clinicians.

Such personal definitions however, are not without controversy. Cutland (1998: 89) for example considers the term problem drinker 'woolly' and believes it "helps society avoid the seriousness of this problem and causes … confusion for the relatives of alcoholics". Whilst acknowledging Cutland's critique the current researcher believes that Velleman's (1992) definition appears consistent with a data driven, inductive qualitative analysis for exploring the lives of partners of problem drinkers. It also allows scope for broad, individual 'diagnosis' to include a range of alcohol misuse from unsafe or irresponsible, to dependent or 'addicted'.

In sum, it is considered disadvantageous to refer to the drinker as an alcoholic as this limits the scope for personal definitions and interpretations, which are seen as more valuable to counselling psychology.

1.2 Counselling Psychology and Alcohol Misuse

Counselling psychologists engaging in clinical practice will most likely encounter clients who are affected by drugs and alcohol misuse (either directly or indirectly) without choosing to specialise within addiction services. Beck, Wright, Newman and Liese (1993) considered it desirable for all mental health professionals to receive some form of training and education in the social and psychological phenomena that comprise the addiction disorders. Similarly, Copello and colleagues (Copello Orford and Velleman, 1996; Copello, Maslin and Velleman, 1998a; Copello, Templeton, Krishnan, Orford, Velleman and Merriman, 1998b; Copello et al. 2000a; Copello, Templeton, Krishnan, Orford and Velleman, 2000b) make important references to potentially detrimental effects of misunderstandings and erroneous assumptions about substance misuse held by health care professionals and relatives or friends of the drinker. They state, "relatives may inadvertently use [coping] strategies that may compound the alcohol problem [although they] are not seen as a cause of the problem" (Copello et al., 2000a: 331-332). Consequently these authors are developing treatment programmes designed to improve the ability of primary care services to offer appropriate, well-informed and competent intervention with concerned others (e.g. Velleman, Orford, Templeton, Copello, Patel, Moore, Macleod and Godfrey, 2011); again this work will be explored later.

Alcohol is one of the most widely used recreational substances today. The majority of people who drink do so without negative consequences to themselves or others. However the Office of National Statistics (ONS, 2013) reports that of all adult drinkers (over 16 years) up to and including 2012 data, more males (29%) than females (21%), were classed as 'heavy drinkers' (more than 8/6 units respectively – twice the Department of Health's recommended maximum daily units), regardless of age. The ONS (2013) also indicate a steadily increasing trend of alcohol-related deaths amongst 35-74 year-olds from 1992-2008, although their latest statistics show 'frequent drinking' to be declining (men 22%-14%, women 14%-9%). More widely, estimates of alcohol's contribution to the Global Burden of Disease (GBD) have shown that 3.7% of all deaths are attributable to alcohol (Casswell et al., 2011). The GBD estimates however underestimate to the total impact of alcohol misuse by omitting the many negative consequences for those living with a problem drinker.

Whilst there is a vast literature on the nature and negative consequences of alcohol misuse on individual drinkers and associated implications for intervention, research with the drinker's family and friends has lagged behind (e.g. Casswell et al., 2011). Although Orford (1984) notes a significant growth in attention to such potentially 'high risks groups' since the

1960's, much of this attention focused on young children, adolescents, and more recently adult children of problem drinkers (e.g. Mackrill, Elklit and Lindgaard, 2012). The needs of *partners* living with a problem drinker still appear relatively overlooked, particularly male partners, although some studies encounter small numbers from which to make tentative comparisons (e.g. Orford, Natera, Davies, Nava, Mora, Rigby, Bradury, Copello, and Velleman. 1998a+b+c; Sisson and Azrin, 1986; Yates, 1988); some notable exceptions (e.g. Philpott and Christie, 2008, exclusively male PPDs) will be addressed later.

NICE (2011) estimates that less than 7% of over one million people who are considered alcohol dependent receive any kind of help, which potentially leaves many family members remaining 'invisible'. It is argued that many 'significant others' who live with someone else's alcohol misuse experience considerable distress (e.g. Alcohol Concern, 2010; 2011; Al-Anon, 1979). Casswell et al. (2011:1087) specifically highlight the need to investigate the "less tangible impacts of alcohol on those other than the drinker", particularly partners. Interest in these 'less tangible impacts' forms an important part of the rationale for the current investigation. Specifically, the current research is concerned to describe and interpret the 'lived experience' of PPDs, as they appear highly at risk and often in need of professional help and support in what is commonly viewed as adverse circumstances.

Delargy (2011) for example, reports that half of all relationship breakdowns are alcohol related (Department of Health, DOH, 2007) and that marriages in which one or both partners have an alcohol problem are twice as likely to end in divorce (Donaldson, 2008). She highlights the fact that when someone develops a serious problem with their drinking many others in that person's family and social circles are affected; notably children and, of relevance to this study, partners. Further, these others are uncertain how best to respond, unsure about where the 'fault' or responsibility lies, upset and frustrated that often "whatever they try to do seems not to make life any easier" (Delargy, 2011: 7), and importantly for counselling psychology they are unsure of how to access appropriate support (Copello, Orford, Velleman Templeton and Krishnan, 2000a). Delargy (2011) also notes that those affected by someone else's problem drinking "commonly develop problems in their own right, often developing high levels of physical and psychological symptoms" (Velleman and Templeton, 2003, cited in Delargy, 2011: 7). Consequently this introduction gives particular consideration to theory and research that views living with a problem drinker as significant adversity and as a potential threat to psychological wellbeing.

Using the Office of National Statistics (ONS, 2013) reveals that middle-aged heavy drinkers, of interest in this study, appears to decrease by age as follows: 45 – 64 years,

men 26%, females 19%; 65+, men 10%, women 6%. The same data sets report that white adults were four times more likely to be frequent drinkers (drinking at least five days a week). Single drinkers (39%) and cohabiting drinkers (36%) were more likely to be heavy drinkers than married (19%) or widowed/divorced/separated drinkers (20%). Adult's *perceptions* of heavy drinking levels are lower than official measures (as above). Of the 14% of all adult drinkers classified as heavy drinkers, less than 1% felt they were heavy drinkers.

Concordance or discordance between couples in respect to alcohol use is also considered an important issue for the quality and often the longevity of partner relationships (e.g. Floyd, Cranford, Daugherty, Fitzgerald and Zucker, 2006; Halford, Bouma, Kelly and Young, 1999; Roberts and Leonard, 1998). Specifically, empirical findings suggest that couples' concordance (either both problem drinking or not) is associated with greater relationship harmony and less psychological distress (e.g. Moos, Schutte, Brennan, and Moos, 2010). Similarly, Delargy (2011) refers to evidence from social work sources (e.g. Forrester and Harwin, 2006) to argue that that illicit drug use, poverty, mental ill health and domestic abuse are often associated with relationships with problem drinkers; although the potential impact of such associations needs to be assessed on an individual basis.

The current research recruited discordant couples in an attempt to describe, understand, and interpret the experience of the non-problem drinking partner who would seem to be maximally exposed to potential harm. In this way we might provide insight into the lives of PPDs and facilitate the provision of effective, evidenced-based intervention for this potential client group.

1.3 The Lives of Partners of Problem Drinkers

As mentioned in the introduction to this portfolio, the current researcher has witnessed some of the damage that a drink problem can wreak on intimate relationships and family life, both in a personal and professional capacity. She has reflected on the disruption, distress, and feelings of powerlessness and indecision that living with a problem drinker can precipitate. Accordingly, one of the 'drivers' for this research was a desire to understand and then potentially inform relevant professionals as to how such individuals and couples may be helped. There are however, a number of difficulties with gaining understanding from a literature review of PPDs. First and foremost is the fact that this group of individuals is relatively 'hidden' and consequently under-researched.

Maslin et al. (1998) note that drinking problems frequently go unnoticed by those outside and sometimes within the family, often due to a partner's struggles to maintain an appearance of normality (Ussher, 1998). This hidden quality creates difficulties for researchers aiming to provide meaningful pictures of the private lives of PPDs. Much of the relatively sparse literature focuses on static quantitative variables such as measures of marital satisfaction and conflict and the occurrence of unpleasant and violent behaviour (e.g. Hanks and Rosenbaum, 1977; Heyman, O'Leary and Jouriles, 1995; Leonard and Senchat, 1996; Powers, 1986; Roberts, 1987; Schurger and Reigle, 1988; Quigley and Leonard, 2000; Testa, 2004; Van Hasselt, Morrison, and Bellack, 1985). Most of these studies of PPDs select particular, often cross-sectional participant groups, and/or employ a variety of psychometric tools and quantitative analyses to test theory-driven hypotheses. This current review explicitly acknowledges literature relating to 'static variables' (factors) and quantitative outcomes (where appropriate, see below), alongside qualitative data given the scarcity of relevant qualitative research available. This 'open' stance to a variety of evidence is consistent with enhancing the academic and professional aspects of the researcher's subjectivity and its vital role in analysing the participant's narratives (see Chapter Two).

A relatively significant body of quantitative (and occasionally mixed-methods) evidence relevant to PPDs stems from research that underpins clinical work within a stress and coping perspective. Although the main emphasis is again on 'static measures' (mainly alcohol- specific coping questionnaires) they do embrace a wider social and cultural context and embrace a dynamic, transactional and more process view of life with a problem drinker.

A highly referenced source, Moos et al. (1990) is representative of cross-sectional study investigating differences in the use of coping strategies between younger spouses of relapsed problem drinkers and a comparable control group. At a 2-year follow-up the spouses of problem drinkers consumed more alcohol and reported fewer informal social contacts than did control spouses. Moreover, they reported more negative life events and less cohesive, less recreation-oriented family environments. In contrast to these differences the two groups of spouses used similar coping strategies. At a 10-year follow-up the spouses of relapsed problem drinkers continued to report a less active recreational orientation in their families, and were more depressed and anxious than were control spouses.

A subsequent study by Brennan et al. (1994) provides a valuable complement to Moos et al. (1990) as it focused on stress and health-related issues within an older sample of

spouses (aged 55-65) of late-life problem drinkers. This is a particularly valuable study partly because it is a rare prospective investigation which also targets a neglected group of older spouses. Spouse participants (n=174 over 60% female) were selected from a sample of individuals who had recently contacted their local medical centres; although they did not differ widely from comparable community samples with regard to health characteristics. Initial assessments collected a range of life-context, health and alcohol-related data which were compared at follow-up a year later. The participants were retrospectively divided into three groups: individuals whose spouse was non-drinker at initial assessment and follow-up (n=87); spouses whose partner had remitted during the year (n=22); spouses whose partner continued to be a problem drinker (n=65).

Comparisons from initial assessments suggested that spouses of problem drinkers had significantly poorer health and social functioning, less supportive family contexts, more stress, and less successful coping than spouses of non-drinkers. Those spouses whose partners remained a problem drinker continued to show poor psychological health and signs of escalating conflicts with children; consistent with earlier work by Black and Meyer (1980). The spouses of partners who would remit during the year showed the greatest positive change in functioning. Given this was a prospective study, Brennan et al. (1994) were able to observe that initially the 22 spouses who would see their partner stop drinking did not appear able to provide "an impetus for recovery". In other words, they were initially indistinguishable from those whose partners continued to drink, but during the follow-up year their health and well-being improved markedly. This study suggests that potentially subtle mechanisms or interactions may underlie the spouse's attempts at coping and the subsequent recovery for some.

Thus far we have an impression that living with a problem drinker causes stress, distress, conflict, marital dissatisfaction, and a strong tendency to cope on the part of PPDs. These issues will be re-visited in a more specific way in later sections. For example, the ongoing work of Jim Orford and his colleagues on coping feature highly in the 'stress and coping perspective' (Section 1.5.2). This same section encompasses a relatively substantial body of literature which suggests interactional and mediational influences are relevant to relationship satisfaction and outcomes (e.g. McCabe, Hughes, Bostwick, West and Boyd, 2009; McKay, 2009; O'Farrell, Choquette, Cutter, Brown and McCourt, 1993; Salinas, O'Farrell, Jones and Cutter, 1991) and these issues are discussed in relation to a systems view of everyday life with a problem drinker. Additionally, more recent work by Moos and colleagues with older PPDs (e.g. Moos et al., 2010) is more valuably discussed in the section on middle-age as an important participant variable (Section 1. 6). For now this

review turns its attention to the relatively small amount of qualitative exploration of the experiences of PPDs. Nielson and Quintana (2005) note that qualitative enquiry is particularly useful for informing therapeutic endeavours, as in this case, due to its discovery rather than confirming orientation, and for its potential theory for theory development; particularly Grounded Theory (e.g. Glaser and Strauss, 1967) and increasingly IPA research (Willig, 2012).

We start with the seminal work by Velleman who works within a stress and coping orientation. His qualitative enquiry, Velleman (1993) highlighted a range of everyday difficulties which he notes can appear whatever the extent or pattern of the drinking problem. Problems included disruptive effects on rituals and routines, altered roles within the family to accommodate the drinker's reduced participation, communication difficulties, effects on family's social life and finances, and the unpleasant, sometimes violent behaviour of the drinker. Similarly Orford, et al. (1998b) identified a "common core of experience" from interview data reported by affected family members in two contrasting sociocultural groups (24 interviews from England and Mexico): The problem user is unpleasant to be with; partners experience financial irregularities and difficulties; concerns over users health or performance; concerns over what the problem is doing to the whole family; personal anxiety or worry; feeling helpless or despairing; feeling low or depressed.

Velleman, Copello and Maslin's (1998a+b) *Living with Drink* conveys rich biographical accounts of six women's experiences of living with a problem drinker. The narratives revealed the shame, embarrassment, and the potential stigma of living with a problem drinker. Partners found themselves making strenuous and varied efforts to cope with difficult, often abusive behaviour. They used a wealth of passive and active modes of communication as the drinker's path becomes increasingly unpredictable. They also faced many difficult choices and dilemmas which demanded increasing amounts of time and emotional investment. Many found themselves increasingly burdened with often sole-responsibility for day-to-day living, particularly if young children were part of the family. Most partners also revealed deep anxiety, distress and uncertainty, leaving them vulnerable to depression. More recently Nolen-Hoeksema, Wong, Fitzgerald and Zucker (2006) examined the effects of a male partner's alcohol problems on depressive symptoms with 202 women over a three-year period. Whilst they found that depressive symptoms were associated with living with a problem drinker, they also found that the women's own alcohol use, anti-sociality, and previous histories were the strongest predictors of female depression (also Hill, 1993). These findings suggest complex, personality and interactional influences which are addressed later.

The women's narratives in Velleman et al (1998a) were interpreted through the 'lenses' of six therapeutically-oriented perspectives, which provided a novel and engaging way of portraying varying orientations. Two of the women took the opportunity to comment on the practitioners' reflections which provided the women with a rare 'voice' and the reader with a rare insight into a 'client's' reflections on therapeutic evaluation. It seemed that these women were appreciative of the commentaries on their stories, and 'May' particularly wished such insight had been available much earlier.

Yates (1988) provides a rare British study of 'co-operative counselling' in which she interviewed PPD's as part of an intervention programme designed to engage problem drinkers into treatment. She made a number of important observations of their concerns and insecurities and provided practice recommendations to form an important underpinning for the study by Howells and Orford (2006), which extended the focus on intervention for PPDs in their own right. The current research also provides counselling psychologists with potentially valuable indicators of 'good' practice; discussed in Chapters Three and Four. Reid (2009), an Australian private practitioner, carried out what I believe to be the only qualitative research study (thematic analysis) to focus exclusively on PPDs (four wives of male problem drinkers). She analysed data from semi-structured interviews and highlighted dominant themes; notably partners' feelings of 'blame' and 'responsibility'.

The descriptions and findings above convey a sense of common experience derived from qualitative analyses of themes or evaluations filtered through a practitioner's therapeutic 'lens' (Velleman et al., 1998a).

More recently, Orford, Velleman, Copello, Templeton and Ibanga (2010b) revealed a similar portrayal of life with a problem drinker in their summary of two decades of qualitative research with 'concerned others'. The majority of the interview data was derived from semi-structured interviews (conducted alongside coping questionnaire measures) in the substantial series of studies by Orford and colleagues in the (e.g. Orford, et al., 1998b as mentioned above) and included participants (mainly PPDs) from the UK, Mexico, Italy, India, Pakistan and Australia. Orford et al., (2010b: 5), 'themed' their findings under four headings, stress, strain, coping and social support, their so-called SSCS model (Orford, Copello, Velleman and Templeton, 2010a) and presented a vivid account of "a key relationship in which the [PPD] has invested so much, or on which so many hopes had been pinned, had gone badly wrong". Specifically, the relationship had become disagreeable and sometimes aggressive, full of uncertainty, worry (predominately about

their drinker), and eventually home and family life are threatened. PPDs are also seen as developing low self-image and self-confidence and are often “badly dented” by their experiences. These authors also provide a useful discussion of the coping responses of their participants, and end with some evidence-based suggestions for the role of professionals working with ‘concerned others’; we return to these inclusions in the section on stress and coping (1.5.2.) and Chapter Four respectively.

In sum, it seems that a problem drinker ceases to be the person they were, and partners increasingly lose their companion often leaving them alone together. This conclusion highlights the need for accepting and sensitive intervention which understands and recognises partner’s concerns, which may include feelings of disloyalty and reluctance to seek help.

Further insight into the potential detrimental effects on mental health and wellbeing associated with living with a problem drinker stems from a small minority of studies which focus their therapeutic intervention on the PPD. Halford, et al. (2001) for example, compared two individual therapeutic approaches (supportive counselling and stress management, and alcohol-focused couples therapy) designed to help female partners of male problem drinkers to deal with stress. Contrary to predictions there was no apparent difference between the interventions. All participants reported a reduction in stress and there seemed no significant effects on their men’s drinking or relationship distress, suggesting a subtle or private benefit.

Rychtarik and McGillicuddy (2005) sampled 171 women from violent and non-violent relationships with problem drinkers to assess the relative influence of coping skills training (CST) and 12-step facilitation (TSF) interventions. Their main focus was the impact on the women’s depressive symptoms, although effects on partners drinking and violent behaviour were also assessed. This study is commended for providing a TSF that was professionally administered and “theoretically distinct” (designed for individuals) and for ensuring that improvement in skill *actually* occurred, neither of which are always the case.

Rychtarik and McGillicuddy’s (2005) findings showed that both programmes lowered the women’s levels of depression which were maintained for 12-months and associated with lowered levels of partner’s drinking. They also reported dynamic interactional processes for PPDs whereby more successful coping generated less negative emotion which provided mutual or reciprocal benefit for both partners. This finding seems consistent with the work of Chang and Sanna (2001) who explored ‘pathways’ between two-dimensional optimism and

pessimism and either depression or life satisfaction (Figures 1.1 and 1.2). They concluded that optimism and pessimism variously influence well-being via emotional (positive and negative affect) mediation. Specifically, the *direct* link from pessimism seems restricted to an increase in depression, whereas, optimism may have the power to directly reduce depression *and* increase life satisfaction.

Fredrickson (1998) provided further support for the benefits of positive emotions (such as joy, interest, contentment and love) believing they offer emotional protection and broaden an individual's thought-action repertoire. Tugade and Fredrickson (2004) elaborated these hypotheses to develop a 'broaden-and-build' theory of positive emotions for understanding resilience. Diener and Emmons (1985) and Deiner, Suh, Lucas and Smith (1999) argue both the independence of positive and negative emotions and their role in well-being. Similarly, Ong, Bergeman, Bisconti and Wallace (2006) posit an important role for positive emotions in resilience and adaptation to stress, particularly in later life. Gruber and colleagues (Gruber, 2011; Gruber, Johnson, Oveis, Keltner 2008) however, advise caution regarding 'too much' positive emotion which mirrors debates concerning too much optimism (Held, 2002, 2004; Sweeny, Carroll and Shepperd, 2006; Sweeney and Shepperd, 2007a+b).

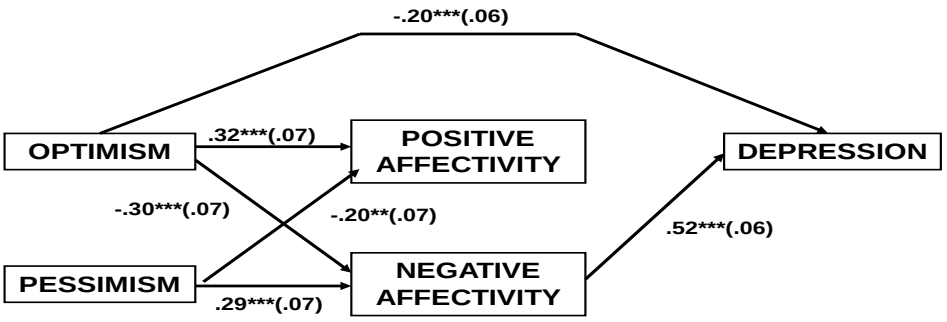

Figure 1.1: Pathways Between Optimism, Pessimism, Affectivity and Depression Numbers in parenthesises represent standard errors. ** P ≤ 0.01 *** P≤ 0.001. Source: Chang and Sanna (2001) p. 528

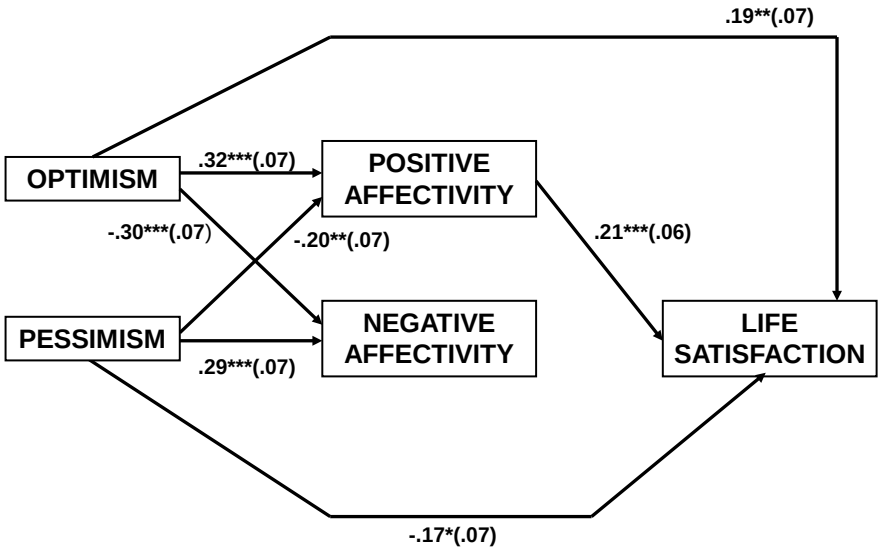

Figure 1.2: Pathways Between Optimism, Pessimism, Affectivity and Life Satisfaction
Numbers in parenthesises represent standard errors. ** P ≤ 0.01 *** P≤ 0.001. Source: Chang and Sanna (2001) p.528

Rychtarik and McGillicuddy (2005) reported equal benefit from the two interventions with the exception that for partners with a history of relationship violence, CST was associated with diminished violence and TSF with worsening violence. Purely speculatively, the TSF may have precipitated a stronger sense of personal autonomy, which changed relationships dynamics in the direction of less 'conciliation' with their drinker's often self-serving behaviour. This possibility raises the therapeutic paradox of finding that an intervention may help one partner at the 'expense' of the other (re-visited in later sections).

In sum, two broad issues of relevance to counselling psychology emerge thus far from reviewing the literature concerning the lives of PPDs: (i) PPDs seem vulnerable to a range of adverse consequences of living with a problem drinker, including concerns for themselves and their drinker; (ii) Many PPDs seem highly motivated to change their problem drinker, which creates opportunities for counselling psychologists to help couples in the same intervention programmes.

1.4 Psychological Intervention for 'Concerned Others'

Copello, Orford, Hodgson, Tober and Barrett (2002) identified four arenas in which intervention might be offered to 'concerned others' (partners, family and friends) of problem

drinkers. The first three, namely: programmes designed to help them 'motivate' their drinker to seek treatment; joint therapy involving the drinker and 'concerned other/s' (predominantly a partner or spouse); joint therapy embracing a wider social network, all focus on helping the partner to help the drinker. Only the fourth arena, individual therapy, regards the 'non-drinker' as client in their own right. Each of these therapeutic directions potentially offers valuable insight, even those which make the drinker rather than the partner their primary focus.

The current research focuses on gaining insight that might be valuable to *partners* of problem drinkers. Accordingly the following sections present a synthesis of traditional approaches to intervention with PPDs, and relevant mainstream domains of psychology. A major impetus for this relatively novel approach to literature reviewing is the realisation that much of the existing research with PPDs has the dual purpose of effecting change in the drinker, where the partner remains relatively invisible; Dittrich (1993) is a rare exception as it considered the impact of the PPD 'in therapy' with their problem drinker. This same consideration is voiced in Roberts (2015) specifically in relation to the perceived usefulness of Behavioural Couples Therapy (BCT), see later, which involves the explicit agreement from PPDs to engage in therapy with their problem drinker.

Consequently, the following sections emphasise theoretical and therapeutic orientations and empirical evidence whose prime relevance is to provide understanding of the day-to-day experiences and therapeutic needs of PPDs in their own right. Later sections will critique the literature pertaining to PPDs in relation to the drinker and the drinking problem.

1.5 Theoretical Perspectives on Partners of Problem Drinkers

A number of major perspectives underlie research endeavour and clinical work in the prevention and management of alcohol problems in family settings. Orford (1984) provides a thorough and useful review of the early work from English speaking countries. Orford (1984) identified six perspectives (whilst acknowledging that other individual perspectives or different combinations of these six could be found): The disturbed personality perspective; stress victim perspective; systems perspective; cultural patterning perspective, ecological perspective and the contagion perspective. Each perspective has taken different starting points which have dictated important matters such as: the chosen targets for treatment or prevention; settings in which the study takes place; methods employed; research questions posed and the kind of research data collected. Some 'negative' terminology (disturbed,

victim, contagion) inherent in aspects of these perspectives indicates a degree of 'pathological bias' in this early work.

More recently Velleman and colleagues (1998a+b), as mentioned previously, 'translated' six PPDs narratives using six influential perspectives. Four perspectives, co-dependency (Cutland), coping (Orford), family systems (Vetere) and community (Fryer) almost 'mirror' the first four presented by Orford (1984). The remaining two, psychodynamic (Cottman) and feminist (Ussher) remain somewhat distinct.

Whilst these perspectives provide a focus and support for research endeavour they may also result in a degree of disjunction between interrelated phenomena. For this specific project the author has amalgamated the above approaches to create three perspectives which seem consistent with both therapeutic work and counselling psychology. This amalgamation addresses one of Ponterotto et al.'s (2008: 467) recommendations for counselling psychologists, which urges them employ and refer to a variety of methods [and sources of evidence] as this will "enhance … [their] flexibility and will promote their ability to act in the role of problem-solving bricoleur in addressing complex counselling and psychotherapy issues". Rich complexity is also consistent with the current researcher's understanding of IPA's 'double hermeneutic' (see Chapter Two).

The three resultant perspectives are: individual differences perspective; stress and coping perspective; cultural and community perspective.

1.5.1 Individual Differences Perspective

This view assumes that partners or spouses are attracted to and remain in relationships with problem drinkers for personality-related reasons. Co-dependency and psychodynamic approaches are considered to offer key insights into individual differences.

The 'co-dependency' or 'disorder personality perspective' (e.g. Lewis, 1937; Whalen, 1953; Futterman, 1953) was the predominant approach up until the 1960's and underpinned most early research and intervention programmes in families with a problem drinker (Orford, 1984); more recently, Beattie (1987), Cutmore (1998), Harper and Capdevilla (1990). From this perspective alcoholism is a disease or illness where the alcoholic is addicted to alcohol and the partner is 'addicted to the alcoholic'. The co-dependency perspective is an offshoot of Alcoholics Anonymous (AA) and subsequently Al-Anon (for families and friends of alcoholics) and incorporates their therapeutic 12-step philosophy (see Appendix 1) in group

support settings. The 12-steps include admitting powerlessness over alcohol, coming to believe that “a Power greater than ourselves (as understood by the individual) can restore sanity”, and ultimately taking the Al-Anon message to others (Al-Anon, 1979). Extending this philosophy to therapeutic work can cause tension with other approaches as we discuss later.

Orford (1984) notes that the almost exclusive concern with excessively drinking husbands and their *wives* is based on a set of assumptions about the marriage relationship which may not be shared by all. This places limits on its value and scope for generalization to cohabiting or homosexual couples, or to partnerships in cultures which adopt different ‘marital’ practices and customs. It may also have fuelled what is seen as the pathologising of female partners, and by default marginalising the perspectives of male partners of problem drinkers. However Cutland (1998) believes that a co-dependency perspective can avoid ‘blaming (female) victims’ and has significant therapeutic value. She refers to enabling actions which effectively collude with or reinforce the alcoholic’s further descent into the illness. Such behaviour needs to be reduced in frequency for the well-being of the co-dependent partner. Cutland’s therapeutic work also emphasises learning to ‘detach with love’ (part of Al-Anon’s philosophy) and encouraging clients to build their self-esteem. Cutland believes that, “recovery from alcoholism is more than putting down the drink, it requires a character transformation” (Cutland, 1998: 97). Hence a PPD may also be helped to a position where such change is mutually desirable.

The early seminal work on co-dependency is well described and evaluated in a number of reviews of family interventions (see Harwin, 1982; Jacob and Seilhamer, 1982; McCrady, 1977; Orford, 1975; and Paolino and McCrady, 1977). This work established a vast and influential literature in a neglected area and provided a platform for alternative approaches and modifications. There are however a number of inherent methodological weaknesses particularly in early studies. These include: limited investigation of interactions *before* drinking was considered a problem; inadequate community control groups; sampling issues with partners and/or alcoholics being studied as if they were a homogenous group; the almost exclusive focus on male problem drinkers. A later review of the co-dependency perspective by Hands and Dear (1994) also highlighted a lack of consensus over the definition of the term co-dependency. This ambiguity provides scope for speculation as to whether alternative explanations and hypotheses may account for some ‘co-dependent’ phenomena; the current research may provide some credible insight.

Psychodynamic approaches also place heavy emphasis on personality variables as important determinants of responses to a problem drinker. A central assumption is that an individual's early experiences of interactions with their care-givers shapes later inter-subjective experiences and their interactions with significant others. Cottman (1998) explains that facing pain or danger provokes a range of negative thoughts and emotions such as fear and a sense of weakness, incompetence and powerlessness. This in turn drives us to find ways of maintaining our sense of control, which usually involves avoidance. Cottman (1998: 106) explains that infants' responses to distressing situations involve screaming and shouting but adults may seek to avoid painful experiences through placation and compliance, and "tune [them]selves totally to other people's demands or expectations". A partner of a problem drinker adopting this stance might seem similarly enmeshed with their drinker as a co-dependent partner, and might benefit from greater psychological distance.

Psychodynamic approaches also propose that a problem drinker might gain temporary relief from 'his' own deep-seated fears (or her own, Shinebourne and Smith, 2009) and suffering by gaining control over a partner in whom he has actively evoked those very fears. Cottman (1998) explains that psychodynamic theory assumes that humans have a powerful fear of 'death' of self by desertion, violence, shame, or censure. Excessive drinking might exacerbate such insecurities so that intimidating a partner could provide some degree of self-protection through distraction. A submissive, self-deprecating or overly-tolerant partner might err towards becoming a 'victim'.

In sum, the 'individual differences perspective' is predicated upon largely dated clinical work, beliefs and assumptions. The current researcher however, believes it is important to keep an open mind regarding such early work and theorising in the event that it resonates with the 'lived experience' of her participants. Such potentially useful anchors will be 'bracketed' during the early stages of data analysis alongside the literature contained within the remaining two perspectives.

1.5.2 A Stress and Coping Perspective

Stress and coping perspectives have provided a major alternative to personality perspectives as they focus on stressful *situations* rather than personality antecedents. The central assumption is that alcohol problems are considered stressful and failure to cope is

potentially detrimental to health[1]. Accordingly relatives are prompted to initiate coping attempts which then moderate stress relationships. A second key assumption of this current stress and coping perspective is that the integration of a 'family systems perspective' will facilitate discussions of inter-personal coping in conjunction with marital (e.g. Rosen-Grandon, Myers and Hattie, 2004) and alcohol-specific (e.g. Cohen and Krause, 1971; Cranford et al. 2011: Ewing, Long and Wenzel: Jacob, 1992; Leonard and Rothbard; 1999; Marshall, 2003; McCrady, 1989) interactional perspectives.

Specific systems perspectives owe their origins to General Systems Theory (GST) which considers the family (or partnership) within a number of wider 'systems' such as neighbourhoods and communities. These wider aspects are considered as part of the 'cultural and community perspective' (1.5.3).

Much of the early work into family systems and alcohol misuse was carried out by Steinglass and colleagues (e.g. Edwards and Steinglass, 1995; Steinglass, 1976, 1981; Steinglass, Bennett, Wollin and Reiss; 1987). Steinglass (1981) suggests patterns of interactions and coping change across the stages of a drinker's path. 'Wet' and 'transitional' stages are characterized by rigid patterns and 'dry' stages with more flexible patterns. However he also noted conflicting evidence as to whether abstinence or drinking provides the most emotional stability. This last point is explored more fully in sections pertaining to concordance and discordance of drinking behaviour.

Orford (1984) describes a 'family systems perspective' as largely concerned with the internal dynamics of families which treats the family as an indivisible system of interdependent parts. Causes for drinking problems are not attributed to any one individual such as the excessive drinker or a 'disturbed' spouse. Family systems theorists and family therapists are interested in the complex interconnections between family members' beliefs, behaviours and relationships, and the dynamic processes by which these develop and change over time. Understanding of these connections and processes is considered crucial for effective problem solving and clearer communication between family members. Vetere (1998) for example discusses 'circular notions of causality' where family members respond to one another's behaviour in cycles or patterns, rather than more traditional linear cause-effect sequences. This approach however has been criticised for de-emphasising individual emotional experience and diffusing responsibility for violent and abusive behaviours.

[1] Jackson's (1954) paper on *'the adjustment of the family to the crisis of alcohol'* is credited by Howells and Orford (2006) as providing the starting point of contemporary stress and coping perspectives.

Heron (1912) and Bacon (1944), cited by Howells and Orford (2006), provide two of the earliest references to marital or relationship problems which seem either caused or exacerbated by alcohol misuse. More recently studies have also shown covariance of alcohol abuse and marital distress (e.g. Davis, Berenson, Steinglass and Davis, 1974; Frankenstein, Hay, and Nathan, 1985; Jacob, Dunn and Leonard, 1983; McCrady, Stout, Noel, Abrams and Belson, 1991: McCrady, Noel, Abrams, Stout, Nelson and Hays, 1986; O'Farrell and Bircher, 1987), and marital problems as predictive of poor prognosis or lack of response in alcohol treatment programmes (e.g. Billings and Moos, 1983; Finney, Moos, Cronkite and Gamble, 1983; Vanicelli, Gingerich and Ryback, 1983). Additionally, stressful marital interactions have been reported to precipitate a return to alcohol by previously 'dry' alcoholics (e.g. Marlatt and Gordon, 1985; O'Farrell, 1986; Maisto, O'Farrell, Connors, McKay and Pelcovits, 1988). Such studies suggest that the nature and quality of intimate relationships are important to the survival rates of partnerships which include a problem drinker and signal consequences for the well-being of PPDs.

A seminal and oft quoted study by Halford and Osgarby (1993) explored the role alcohol played in people's quest for marital therapy; in other words they had acknowledged relationship difficulties. These researchers screened 84 men and 56 women for alcohol abuse (3:1 male-female alcoholics), current marital disagreements around alcohol abuse, and reported domestic violence as a precursor to marital therapy at a marriage guidance clinic. Their findings confirmed associations between alcohol problems and severe marital distress with 80% of participants reporting marital disagreements about alcohol abuse at least "frequently". Moreover, alcohol problems generated a greater source of "frequent" disagreement than other common sources of marital disagreement such as, household chores, finances, use of leisure time, communication, sex, and parenting. Alcohol abuse issues were also linked to more steps being taken towards divorce and greater male aggression. Virtually 70% of respondents reported the occurrence of physical aggression in their relationship and that pushing or shoving occurred in their relationships at least "occasionally". These findings valuably suggest mutual benefits in addressing coexisting alcohol and marital problems.

Kahler, McCrady and Epstein (2003) examined sources of distress among women in treatment with their alcoholic partners. Greater psychological distress for these women was most strongly associated with lower satisfaction with the marital relationship, presence of domestic violence, lower perceived social support from family, and more frequent attempts

to cope with the partner's drinking. Controlling for psychological distress, greater marital satisfaction was associated most strongly with greater attempts to positively reinforce the partner's abstinence and with less efforts to detach from the partner's drinking. It seems these women prefered to be involved in the process of recovery.

Kahler et al. (2003) valuably note the persistence of alcohol-related problems despite controlling for associations between the non-alcoholic partner's functioning and both demographic characteristics and other negative life events. They also quote evidence to counter early suggestions that partners of alcoholics possess 'enduring pathological traits' (e.g. Lewis, 1937) by finding no significant differences with a sample of females drawn from the community. Similarly, Copello et al. (2000a) notes that theories which place responsibility on the *non*-drinker can lead to unhelpful or erroneous attitudes among health care professionals.

Kahler et al. (2003) report what they believe is a previously unreported and unexpected finding - a positive association between severity of the partners' alcohol problems and marital satisfaction in multiple regression analyses. In other words, *lower* frequency of male drinking predicts greater distress. They suggest a connection to the work of Jacob et al. (1983) who investigated family responses to steady versus episodic drinking. Specifically, they wonder whether spouses may cope better with a regular, predictable pattern of drinking as compared to a more erratic pattern; similarly Edwards and Steinglass (1995). The current qualitative research may shed light on this last issue.

Floyd et al. (2006) also recognize the 'destructive effects of alcoholism' on marital outcomes but believe the homogeneity of samples impede exploration of possible mechanisms of influence. Usefully, Floyd et al. (2006) compared verbal and non-verbal problem-solving interactions of couples in four alcoholic subgroups; husbands with antisocial personality disorder[2] or not, paired with alcoholic or non-alcoholic wives. The participants were middle-aged, white, couples (mean ages: men, 38; women, 35) who agreed to be videoed during 'conflict discussions', which were coded, generating relative frequencies between categories of interaction: Negative (e.g. putting down, blaming); Neutral (e.g. providing information, asking questions); Positive (e.g. empathy, agreement).

[2] Common co-morbidity – but these authors recognize a number of confounding factors such as earlier onset of drinking, childhood problems and other psychopathology.

It seems couples with an antisocial alcoholic husband had higher levels of hostile behaviour regardless of wives' alcoholism status. In contrast, rates of positive behaviours and the ratio of positive to negative behaviors were greatest among couples in which either neither or both had an alcoholic diagnosis. This finding is consistent with notions of 'drinking partnerships' advanced by Roberts and Leonard, (1998). Although the alcoholic wife and non-alcoholic husband group was considered too small to provide firm conclusions on the 'power' of concordance, taken together, Floyd et al.'s (2006) findings highlight antisocial alcoholism and discrepant alcoholic diagnosis in poor marital outcomes. Unsurprisingly then, remaining with a problem drinker is not the norm. These researchers also advocated further research to consider factors which might be implicated in tipping the balance to divorce and separation, as causal connections seem complex and remained a considerable source of speculation.

Orford and colleagues have been exploring and refining structures of alcohol-specific coping in relation to psychological distress and familial conflict since the 1970's (e.g. Copello et al. 2000a+b, 2002, Copello, Templeton, Orford and Velleman, 2010; Krishnan, Orford, Bradbury, Copello and Velleman, 2001; Orford et al. 1998a,b,c; Orford, Copello, Velleman, and Templeton, 2010a; Orford, Guthrie, Nicholls, Oppenheimer, Egert and Hensman, 1975; Orford, Hodgen, Copello, Wilton, and Slegg, 2009a; Orford, Natera, Velleman, Copello, Bowie, Bradbury, Davies, Mora, Nava, Rigby and Tiburcio, 2001; Orford, Oppenheimer, Egert, Hensman and Guthrie, 1976; Orford, Rigby, Tod, Miller, Bennett and Velleman, 1992; Orford, Velleman, Copello, Templeton, and Ibanga, 2010b; Velleman, Orford, Templeton, Copello, Patel, Moore, Macleod and Godfrey, 2011). Consequently Orford's (1998) well founded and pragmatic definition of alcohol-specific coping is preferred to more 'formal' mainstream definitions as it is not limited to 'successful' coping:

> "The ways of understanding reached [by the individual under the coping lens] at a particular point in time, and ways of responding are what are referred to collectively as 'coping', [which is] not limited to well-thought-out and articulated strategies, nor to ways of understanding or responding that the [individual] believes to be effective, although these are included" (Orford, 1998: 129).

Orford (1998) provides rich and 'everyday' examples of coping consistent with his definition which suggest an experienced and accepting stance towards those whose lives are affected by drink. Coping for example can include, feelings (from anger to hope); philosophical positions reached, 'stands' taken, and tactics tried once or twice and quickly abandoned. In sum, from a coping perspective a drinking problem in the family is a multi-

faceted challenge to well-being and attempts to cope, regardless of their 'success', are seen as normal responses to difficult situations.

Since 1998, papers by Orford and his colleagues have reported a valuable series of studies comparing two contrasting socio-cultural groups in relation to the stress-coping-health model of alcohol, drugs and the family (Orford et al., 1998a;b;c;, 2001). This research was designed partly to shift from the almost exclusive focus on intra-family factors (e.g. Dorn, Ribbens and South, 1987; Love, Longabaugh, Clifford, Beatie and Peaslee, 1993) to wider social and cultural considerations. This consideration provides further justification for the inclusion of a GST approach. One hundred close relatives (mainly partners or parents) from separate families in Mexico City and SW England were recruited. Both quantitative (standard questionnaires) and qualitative interview data were analyzed in order to test hypotheses derived from the stress-coping-health model for each cultural group.

Three broad dimensions of commonly used alcohol-specific coping strategies (cognitive and behavioural) were identified; after failing to support an earlier working typology of eight common ways of coping reported by Orford et al. (1992)[3]. Orford et al. (2001) concluded that the structure of coping could best be described in terms of three factors: engaged; tolerant-inactive and withdrawal.

For both Mexican and English samples tolerant-inactive coping was associated with greater distress among relatives of alcoholics as it seemed positively correlated with family conflict and negatively with a positive family climate (Orford et al., 2001). Engaged coping, characterized by attempts to change the drinker, was also correlated positively with family conflict in the English sample, and with greater distress in both samples. The findings for withdrawal coping were less overtly clear as absolute values did not yield any significant associations. However, withdrawal scores corrected in relation to totals generated negative correlations with symptom reporting, suggesting relationships to good health and well-being. More recently, Philpott and Christie (2008) found similar profiles and associations of coping in a rare sample of 29 male partners of female problem drinkers; despite contrary predictions for male PPDs. Orford and colleagues (1998b) also provided rich and valuable qualitative analyses revealing important subtle distinctions and complexities within strategies often 'missing' from undifferentiated combined forms of coping. Specifically they

[3] "Controlling, emotional, avoidance (withdrawal from the user), inaction, tolerance, support for the user, confrontation (assertion) and independence" (Orford et al, 1992: 1801).

suggest their three strategies are not totally independent, may result in functional or dysfunctional responses, and may be sensitive to the philosophies of those drawing the distinctions. These conclusions are consistent with their more recent publication of the qualitative analyses from this research (Orford et al, 2010b) in which they emphasize the complexity, normality and individuality of relatives' coping efforts. They believe that "all forms of coping have points in their favour the balance depending on family circumstances" (ibid: 19). They do report however, that many interviewees appreciate that some strategies become counter-productive, such as confronting the problem drinker in ways that are hostile or aggressive and attempting to exercise excessive control (e.g. closely monitoring the drinker's movements and searching for and destroying their alcohol).

Kahler et al. (2003) also believe measures of alcohol-specific coping provide clearer, more therapeutically relevant descriptions of the associations between coping and psychological distress among spouses of alcoholics. They distinguish four coping factors: Confrontation and Control; Avoidance of Confrontation; Detachment; and Positive Consequences of Sobriety. There appears to be a degree of both overlap and distinction with the three factors isolated by Orford and colleagues. This is argued here as positive as it is consistent with expectations of diversity and individual difference within the current research.

So far the discussion has concentrated on alcohol-specific coping, but there are some important links and insights from mainstream theory and evidence. Whilst Selye's (1976) General Adaptation Syndrome / physiological response model and Holmes and Rahe's (1967) stimulus view of stress offer valuable perspectives, foremost are transactional theories of stress and coping which regard the experiencing of stress as the result of complex, dynamic processes of an individual's appraisals of their environment. This approach can be traced to psychologists such as Lazarus and Launier (1978), Lazarus and Folkman (1984), Folkman and Lazarus (1985), Folkman, Lazarus, Dunkel-Schetter, Delongis and Gruen (1986) and more recently Folkman and Moskowitz (2000, 2007). Such approaches to stress emphasise the mediating effects of a number of individual variables such as personality traits, predispositions to anxiety, amount and type of social support, and the influence of past experiences.

A central tenet of a transactional approach is the *process* of reciprocal causation between the environment and the individual. Folkman and Lazarus (1985) concluded that, "a

stressful encounter should be viewed as a dynamic unfolding process, not a static unitary event" (p.150). Stress is defined as:

> "a relationship between the person and the environment that is appraised by the person as relevant to his or her well-being and in which the person's resources are taxed or exceeded" (Folkman and Lazarus, 1985: 152).

Appraisals are divided into primary appraisals where an individual judges whether an encounter is irrelevant (no stake in it), benign-positive (good outcome is signalled) or stressful (characterised by feelings of threat, challenge, harm-loss)[4]. Secondary appraisals relate to evaluations of coping resources and options, addressing the question - 'what can I do'? Specifically, coping is divided into problem-focused and emotion-focused-coping. Primary and secondary appraisals are considered to operate interdependently.

Folkman and Lazarus (1985) proposed a central role for affective experience in the stress process. Specifically (fifteen) emotions vary in quality and intensity and are generated by particular appraisals as follows: Threat - worried, fearful, anxious; Challenge - confident, hopeful, eager; Harm - angry, sad, disappointed, guilty, disgusted; Benefit - exhilarated, pleased, happy, relieved. Threat and challenge are further classified as anticipatory, whereas harm and benefit are regarded as outcome emotions. Bradding (1995) replicated and extended Folkman and Lazarus's (1985) investigation and supported the conceptualisation and perception of stress and coping responses as rich, dynamic, individually construed processes.

Of note, Philpott and Christie (2008) and Rychtarik (1990), both involved in alcohol-specific research, also make links to mainstream transactional models of stress and coping. Following Folkman and Lazarus (1984) they propose that changes in coping (from more 'engaged' to 'withdrawal') are linked to the length of time that a PPD have been attempting to cope. Increasing time is associated with desensitization and reduced efforts to modify, resolve, or overcome stressors, leading to avoidance. In turn, these arguments resonate with the processes of 'learned helplessness' (e.g. Abramson, Seligman and Teasdale, 1978).

The above discussions of transactions and mediations of personal and/or relationship characteristics in relation to stress and coping, prompted the current author to include

[4] Threat refers to the potential for harm or loss; challenge refers to the potential for growth; harm-loss refers to injury already done e.g. harm to a friendship, health, self-esteem.

interactional models as part of the everyday contextual milieu of PPDs. For example Rosen-Grandon et al. (2004) used structural equation modeling (based on previous formulations and evidence[5]) to identify pathways from marital characteristics (love, loyalty, shared values) through interactional or interpersonal processes (communication, expression of affect, sexuality/intimacy, consensus, egalitarian roles, conflict management) to varying levels of marital satisfaction; two moderating variables being length of marriage and gender of participant. Somewhat similarly, Cranford et al. (2011) carried out a longitudinal study which explored the associations between marital interactions (ratio of positive and negative behaviours) 'through' the partners' alcoholic status as predictors of marital adjustment. They draw upon Karney and Bradbury's (1995) model regarding the quality and stability of relationships - Vulnerability-Stress-Adaptation Model (VSAM). VSAM includes three classes of variables: i) enduring vulnerabilities (stable personality characteristics); ii) stressful events (acute and chronic stressors such as financial strain); iii) adaptive processes (the behaviours that spouses exchange – e.g. marital interactions that involve problem solving or provision of social support). They proposed that variables (i) and (ii) may have independent effects on marital satisfaction, but also mediated by marital interactions; "any variable that affects a close relationship can do so only through its influence on ongoing interactions" (Karney and Bradbury, 1995: 23). Interactional models such as these remind us that problem drinking is merely one aspect, albeit an important one, in the dynamic complexity of sharing our lives with a partner.

The literature pertinent to the 'stress and coping perspective' encourages us to appreciate the enormous process and interactional complexity involved in the lives of those living with someone else's drink problem. The remaining 'cultural and community perspective' adds enormous intra-psychic and socio-cultural complexity to an already rich and diverse picture of the lives of PPDs.

1.5.3 Cultural and Community Perspective

So far reviews of the literature has been discussed as if concepts such as stress, coping and personality variables provide 'clear windows' into the minds of the possessor. They have made little reference to peoples' personal beliefs, attitudes, assumptions or cultural heritage beyond any that form an integral part of their respective measuring instrument.

[5] For example: Marital characteristics – Collins and Coltrane (1991); Fenell (1993); Glenn (1990); Kurdek (1991); Larson and Holman (1994); Lauer, Lauer and Kerr (1990); Lewis and Spanier (1979); Robinson and Blanton (1993); Mackey and O'Brien (1995)

Meta-cognitive theory (e.g. Wells, 2000) is seen as potentially valuable in gaining an understanding of how beliefs *about* concepts and personality variables influence the expression and endorsement of pertinent constructs. Allott, Wells, Morrison, and Walker (2005) for example, carried out what they believe was the first investigation of meta-cognitive beliefs in relation to distress associated with chronic illness (Parkinson's disease). Following the 'self-regulatory executive function model' (Wells and Matthews, 1994) they propose that, "people hold beliefs about their own thought processes and these guide their responses to distressing cognitive or body state intrusions" (p.182). They identified what they called a "more maladaptive meta-cognitive style" associated with heightened distress. It seems that people who held stronger beliefs about worry which focused on uncontrollability and danger were more likely to report unhelpful anxiety and fear. Although Allott et al. (2005) explored meta-cognitions with 'sufferers' their findings could be argued as relevant to the emotional distress and 'normal', functional worry component of pessimism (see, Alloy and Abramson, 1979; Leader, 2008; Norem, 2001, 2002; Peeters, Cammaert and Czapinski, 1997; Waller, 2003) seemingly experienced by PPDs.

McGrath, Montgomery and White (2006) looked at how differing personal constructions of the value and purpose of positive thinking or optimism lead to very different consequences for bereaved wives. They provided poignant comments concerning the narratives of two wives whose husband's died from renal cancer: For 'Sigrid' positive thinking meant take the opportunity to communicate, enjoy the moment, but also involved planning and preparation for her husband's imminent death. For 'Delia' it meant denial and escape, which left her alone in "a very dark place". Such potential mediators of communication will be discussed in the following chapters and will form part of the interpretative aspects of IPA.

Work on personally construed meaning has been heavily influenced what are known as socio-cognitive approaches. For example Dweck and Leggett (1988) established a firm foundation for considering how peoples' fundamental assumptions (i.e. lay theories) about the nature of psychological phenomenon, the self, and their social worlds can create cognitive structures and processes; these in turn significantly determine day-to-day perceptions and responses. Specifically they considered the implications of endorsing 'entity theory' (believing traits to be fixed and unalterable) or 'incremental theory' (allow the possibility of change through personal effort/agency) with regards to personality and intelligence to derive a 'helplessness' versus 'mastery' orientation respectively.

Molden and Dweck (2006) widened this lay theory approach to include the psychological process of self-regulation in the face of adversity, including the expectation of threat,

conflict or rejection in close relationships. For example assigning stable, negative traits to explain a partners' antisocial behaviour leads to escalation of conflict and hostility (Bradbury and Fincham, 1992). It seems,

> "… the self-regulation people are able to immediately exercise in response to setbacks, particularly when cherished abilities and identities are directly threatened, can often determine whether they are able to recover and resume pursuit of their larger goals" (Molden and Dweck, 2006: 194).

The above lay models and conceptualisations seem to act as bridges between intentions and outcomes. For example an unexpected finding from Strack et al. (1987) suggests a need to understand individual meanings on psychometric measures. Drinkers-in-recovery who reported a relatively high incidence of uplifts were more likely to *fail* to complete the programme than those with less. One possible explanation was that many uplifts are what people normally associate with causes for celebration and hence drinking, which could create pressures towards returning to a drinking culture. This resonates with Orford, Rolfe, Dalton, Painter, and Webb (2009b) who provided qualitative insight into what problem drinkers may lose by giving-up alcohol and staying away from the pub. For women and their metacognitions around alcohol use, particularly in a partner, we can usefully look to social psychology, sociology, feminist, media, and/or discourse literature (e.g. Barker, 2013; Gill, 2006; Ussher, 2000) and alcohol-specific discussion (e.g. Holmila, 1998, 1994, 1997; Jarvinen, 1991; Raine, 2001; Ussher, 1998), which will be more fully discussed within the analyses and discussion chapters.

A socio-cultural approach can embrace the benefits of qualitative enquiry for counselling psychology as it emphasises emotive and cognitive aspects of people's experience (Ponterotto et al., 2013). In turn this facilitates IPA's 'return' to "a science of [idiographic, cognitive] meaning and meaning-making rather than a science of information-processing" (Smith and Eatough, 2006: 325), which resonates with the current researcher's academic subjectivity. The following section provides a critical review of the literature on middle-age as an important mediator of metacognitions in relation to the current research.

1.6 Middle-Age as a Mediator of Metacognitions

Brennan et al. (1994) provide support for middle-age being 'special' in the context of living with a problem drinker. This study was designed to test age-related predictions with mid-later life spouses of problem drinkers in order to compare with the younger spouses recruited by Moos et al. (1990). They wondered whether older spouses would experience

more stress, given other challenges such as retirement and additional health problems (see Allen, 2008; Blekesaune, Bryan and Taylor, 2008; NICE, 2005) or less, given their greater experience and increased personal resources. Both groups reported significant stress and unhappiness, but one of the most interesting findings was the combinations of coping strategies used by the middle-aged spouses. These individuals seemed to rely heavily on two contrasting coping strategies, cognitive-approach strategies (positive-reappraisal) and shared or symmetrical avoidance-coping (resigned-acceptance), which are consistent with optimism and pessimism respectively (e.g. Carver and Scheier, 2002).

A study by Herzberg, Glaesmer and Hoyer (2006) lends further support to possibility that middle-age may be associated with important differences in the experiencing of optimism and pessimism. These authors concluded that optimism and pessimism become more independent[6] of each other with increasing age, showing maximum independence in middle-age (Figure 1.3). This finding suggests that (high or low) optimism *and* pessimism are equally salient for this age group.

As an aside, Herzberg et al.'s (2006) description of increasing independence masks two sections of the age profile which break the continuity of this trend: A *decrease* in independence (increase in negative association*)* between 18-24 and 25-31, then a further increase in positive association beyond maximum independence (0.0 shown at 60-66). Given the huge sample in this study (over 46,000 participants) it is likely that these sections indicate further research for substantive differences rather than representing statistical anomalies. These anomalies show some consistency with Casswell et al.'s (2011) survey of self-reported life satisfaction, health status and resultant risk to well-being with individuals (12–80 years) living with a problem drinker. The younger and older age groups appeared to experience the highest levels of subjective well-being, leaving middle-age people in a seemingly ambiguous position.

[6] A number of researchers are challenging the simplicity of one-dimensional conceptualisations of optimism and pessimism and are exploring the possibility of a two-dimensional conceptualisation, in which two dimensions co-exist as optimism / not-optimism, and pessimism / not-pessimism (e.g. Chang and Sanna, 2001; Herzberg et al., 2006; and others).

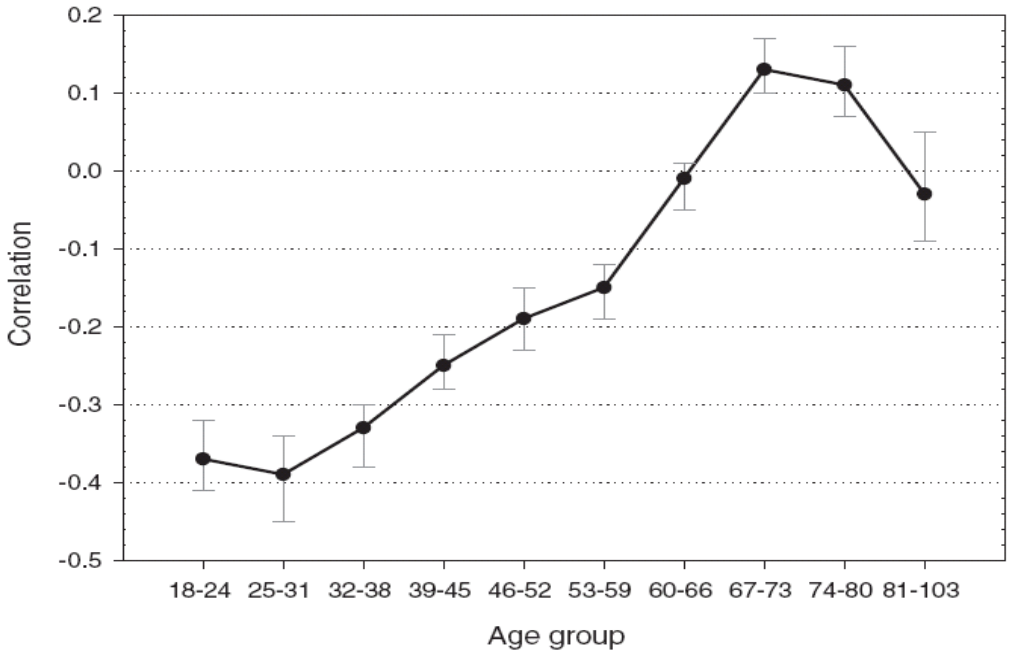

Figure 1.3: Correlations Between the Latent Variables Optimism and Pessimism for Different Age Groups, with 90% confidence intervals. Source: Herzberg et al, 2006, p.436.

This survey data was derived from a cross-sectional design which places limitations on conclusions of causality, but it signals middle-aged individuals as experiencing a greater mix of thoughts, emotions and psychological concomitants of living with a problem drinker. Casswell et al. (2011) acknowledge that not all factors known to be associated with life satisfaction and health status could be controlled for, which encourages the current researcher to consider whether middle-aged participants might demonstrate greater 'fluidity' of metacognitons, balances of optimism and pessimism and flexibility of coping strategies.

Of note, the designation middle-aged is viewed as increasingly difficult to identify due to the increasing longevity of UK populations (ONS, 2013), and an apparent 'older-shift' in the occurrence of mid-life transition and mid-life crises (Robinson and Smith, 2010; Robinson and Stell, 2013; 2014). Robinson and Stell (2013) for example, report evidence that mid-life crises are far more prevalent in individuals aged between 50-65 years rather than in people in their 40s. They also reported a degree of ambivalence between post-crisis growth[7] and despair, struggles between 'integrity' and 'disengagement', the importance of 'voluntary' versus 'forced' crises and the growing acknowledgement of reduced time horizons. Such population shifts and balances are hypothesised to have a significant impact on

[7] These authors report four significant aspects of post-crisis growth (in those who have experienced crises between the ages of 60-69). Percentage endorsements in four key domains of wellbeing were as follows: Resilience 42%; Self-esteem 50%; Positive changes 48%; Quality of life 44%.

metacognitions and perceptions of psychological well-being, and have a bearing on existing research with middle-aged participants, as in this research.

Moos et al. (2010) for example, compared concordance and discordance of high-risk alcohol consumption in what they term older couples (55-65); these would be Robinson's (2013) 'new' middle-aged individuals. Previous studies, consistent with the idea of 'drinking partnership' (concordant), show younger and middle-aged (35-45) couples experiencing higher marital satisfaction (e.g. Floyd et al., 2006; Roberts and Leonard, 1998); less is known about these so called older couples. Moos et al. (2010) conducted a longitudinal study which gathered based-line measures with a follow-up 10 years later. Married couples (no further criteria given) provided self-report ratings of each partner to questions related to behaviours such as such as skipping meals or having a fall due to drinking, and interpersonal problems such as whether family members or friends expressed worries about drinking. These researchers deemed the endorsement of one of more items signalled a drinking problem.

Moos et al.'s (2010) findings showed that husbands and wives in high-risk concordant, and husbands in discordant drinking relationships, were more likely to incur drinking problems. They also suggested that continued high-risk drinking may lead to conflict and withdrawal of extended family members. There was however, a noticeable moderation of drinking with age, especially for husbands in discordant relationships and a more general trend towards lower alcohol consumption in later life. Interestingly these transitions were predicted by the husband's participation in domestic tasks at base-line, which may foreshadow a closer spousal relationship and less need for either partner to engage in high-risk alcohol consumption. Also shifts from discordant couples to low-risk concordant was due almost entirely to husband's transition from high-risk to low risk concordance.

Moos et al. (2010) also observed that a husband's drinking appeared to have less influence on his wife and posit that, "with increasing age, women tend to become more assertive and independent, whereas men become more responsive to interpersonal and social context" (p.332). To temper these potentially valuable findings Moos et al. (2010) acknowledge that more frequent assessments, in conjunction with richer information about the couples' social contexts, would enhance analysis, interpretation, and generalisation. This last findings is however consistent with studies of problem drinking and pub-culture (e.g. Orford et al., 2009b), which signal differences in metacognitions and individual phenomenological worlds.

Despite participant group limitations, (couples were primarily Caucasian and relatively well-educated), Moos et al. (2010) are commended for valuably looking beyond differences in concordance to highlight the importance of their couples' day-to-day lives; whether they share domestic tasks, or talk to each other in mutually beneficial ways. The existence of mutual concern seems implicit in many of the studies which involve partners in intervention programmes designed to help the drinker reduce or abstain from drinking.

Of note the current researcher is middle-aged and this fact of her subjectivity will have assimilated and valued both the reported previous research and the participant's stories through this particular 'lens'; which is considered predominately generative and positive.

1.7 The Role of Partners in their Drinker's Path

This section reviews studies of joint involvement (minus Moos et al., 2010 reviewed above) in alcohol reduction programmes. The purpose being to glean insight regarding behaviours, stances and personal qualities that might be used by counselling psychology to inform concerned PPDs.

A number of authors (e.g. Miller, Meyers and Tonigan, 1999; McCrady and Epstien (1999); McCrady, Epstein and Hirsch, 1999) observed that 'concerned significant others' (CSO) often request help in in dealing with 'loved ones' who are unmotivated to change alcohol problems. Such requests are viewed as a common clinical problem for both partners. Family interventions designed to reduce or stop the problem drinker from misusing alcohol are broadly divided into (i) those that target the PPD who then put acquired strategies into action, or (ii) those that involve joint or family therapy.

Miller et al. (1999) provide a representative example of 'working through' the PPD to compare three interventions designed to encourage their drinker into seeking help. They provided 130 participants with one of three different counselling approaches: An Al-Anon facilitation therapy to encourage the drinker to participate in 12-step programmes; a Johnson Institute intervention[8] which aimed to prepare CSO's for confrontational family meetings; a community reinforcement and family training approach (CRAFT; similarly, Meyers, Miller, Hill and Tonigan, 1999) which provided behaviour skills to use at home. All

[8] "Family members are prepared to confront the problem drinker with what they have experienced and observed about the drinking and related problems. In a caring and supportive manner the drinker is encouraged to enter treatment and sanctions may be applied for failing to do so" (Miller, et al., 1999: 691).

interventions were manual-guided and involved 12-hours personal contact and follow-up interviews for 12 months.

Miller et al.'s (1999) findings showed the CRAFT approach as the most effective in engaging initially unmotivated drinkers to treatment (64%). The Johnson Institute approach yielded only 30% of participants who were prepared to confront their drinker; although those who did showed a 75% success rate in getting the drinker to treatment. The Al-Anon intervention generated a 13% success rate. Despite differing 'success' rates for facilitating the drinker into therapy all three approaches were associated with similar improvements in CSO psychological functioning and relationship quality.

An important criticism of Miller at al.'s (1999) study is the exclusion of drinkers with a history of domestic violence due to concerns that changes in coping by their partner might precipitate a violent reaction. This decision resonates with Robson's (2011) concern with ethical issues inherent in research involving potential change. However, restricting samples to non-violent drinkers limits generalizability. Gondolf and Forster (1991) for example, reported that at least 50% of untreated problem drinkers have violent tendencies. A further criticism concerns the Al-Anon approach which is considered an inappropriate comparison by being designed as *group* support for the PPD and not to bring unmotivated drinkers to treatment (Rychtarik and McGillicuddy, 2005).

Despite these criticisms Miller et al.'s (1999) study provided valuable insight into important challenges faced by those closely involved with problem drinkers. It alluded to the difficulty of attempting to control and regulate personal distress whilst finding the time, energy and assertiveness to encourage often intransigent drinkers into self-improvement. More specifically it indicated a high level of resistance or possibly inability to *confront* problem drinkers, although unfortunately participants' reasons were not made explicit; refer back to Moos et al. (2010) who report an increase in female assertiveness with age.

Barber and Crisp (1995) reported a 'pressure to change' approach to working with partners of what they call 'resistant' drinkers. They focused on a stage in the drinker's path before they considered seeking help; termed a pre-contemplator (from motivational interviewing: e.g. Arkowitz and Westra, 2009; Miller and Rollnick; 2002[9]). The authors acknowledge this stage as one where PPDs often need most urgent help. The 'pressure to change' approach

[9] Originally devised by Miller (W. R.) in 1983.

involves training partners how to use five levels of pressure[10] to encourage their drinkers to seek help or moderate their drinking. This approach recognises that a partner's punitive or controlling behaviour is often counter-productive, whilst protective or placatory stances may act as types of positive reinforcement or 'reward' for the drinker; it also recognises the importance of confrontation (Level 5 'pressure') .

Barber and Crisp's (1995) recruited 22 women and one man and randomly allocated them to the treatment group or a no-treatment 'waiting list'. Findings showed that almost two-thirds of the drinkers took significant steps towards change. This study raised the important issue of the specific spouse characteristics and behaviours that might predict such positive outcomes. Specifically they questioned the presumption that 'successful' spouses facilitated emotional well-being by being more supportive; they suggested that an 'uncomfortable' relationship encourages remission. This last statement was not supported by evidence or reference, therefore could not be followed-up. Studies such as Sobell, Sobell, Toneatto and Leo (1993), Brennan et al. (1994), McCrady et al. (1999), agree that PPDs help moderate drinking problem and prevent relapse by helping drinkers recognise their drinking problems, although they acknowledge ambiguity regarding the personality or interactional qualities that are most instrumental. Such issues would benefit from sensitive interviewing or observation and may be addressed by the current research.

A number of joint involvement programmes employ Behavioural Couples Therapy (BCT) designed to increase harmony in relationships and reduce problem drinking. BCT includes specific objectives, namely, positive communication, shared activities and negotiation of agreements, all of which are positively correlated with marital satisfaction (Klostermann, Kelley, Mignone, Pusateri and Wills, 2011).

An early study by O'Farrel, Cutter and Floyd (1985) randomly assigned three groups of couples to counselling and 12-step programme, counselling and group intervention and counselling and BCT. Findings showed that the all men, regardless of group, improved as measured by recording more non-drinking days. However, only those from the BCT group reported relationship benefits at a two-year follow-up. These findings are similar to McCrady et al. (1986) and more recently Vedel, Emmelkamp and Schippers (2008), where BCT was associated with a significant reduction in problem drinking and greater relationship satisfaction, respectively.

[10] The five levels are: Level 1 – Feedback and education; Level 2 – incompatible activities; Level 3 – responding; Level 4 – contracting; Level 5 – confrontation.

Fals-Stewart, Bircher and Kelley (2006) carried out a rare investigation of 138 female alcoholics in joint-therapy with their male partners. The women were randomly assigned to one of three equally intensive interventions: behavioural couples-therapy with individual-based treatment; individual-based treatment only; psycho-educational attention treatment. During treatment there was no significant difference in drinking frequency between the three groups, although behavioural couples' therapy appeared associated with a significant improvement in dyadic adjustment. At a 1-year follow-up behavioural couples-therapy signalled fewer days drinking, fewer negative drinking-related consequences, greater relationship satisfaction and reduced partner violence.

Fals-Stewart et al. (2006) provided valuable insight into female problem drinking whilst acknowledging a pressing need for further investigation with this under-represented group. They also provided tentative, gender-linked therapeutic considerations. Specifically, women appear to acknowledge drink problems earlier, are younger, poorer, more likely to have children, receive less emotional support from intimate partners, and present with a higher prevalence of psychiatric disorders such as depression and anxiety. These differences may be associated with significant differences in experience of male PPDs.

A number of other potentially valuable findings can be gleaned from more recent BCT studies which also recruited female problem drinkers. For example, Green, Pugh, McCrady and Epstein (2008), found that virtually 50% of their female problem drinkers indicated marital disharmony, specifically arguments with their partner as reasons for drinking; Lemke, Brennan and Schutte (2007), highlighted more general family problems and emotional distress were linked to relapse; Graff, Morgan, Epstein, McCrady, Cook and Jensen (2009) noted the importance of satisfying marital relationships in sustaining engagement with treatment sessions and McCrady et al. (2009) noted the most significant improvement (measured in percentage of days abstinent) stemmed from female problem drinkers with the poorest baseline relationship functioning. The findings above may go some way towards informing us as to which of the treatment components accounts for the largest variance of change.

In sum, all of the studies which involve PPDs in joint interventions with their problem drinker provide rather impoverished evidence of the specific characteristics, strategies, or the more 'everyday' responses of PPDs. The addition of such 'everyday' experiences might facilitate the development of individual intervention or therapy. Similarly, from the problem drinkers' point of view, Klostermann et al. (2011: 1507), conclude, 'despite BCT's demonstrated efficacy, there are large individual differences in patient response to treatment, including no

response'. This conclusion is relevant to debates concerning so-called manualised therapy, which err towards a 'one-size-fits-all' perspective and more adaptive, flexible, individualised interventions.

1.8 Positioning the Current Study

The main aim of this introduction was to critically review empirical insights into the lived experience of *partners* of problem drinkers, given that they present to counselling psychology as potentially vulnerable individuals. Velleman et al.'s (1998) *Living with Drink* for example, provided six 'biographies' of PPDs which revealed poignant and often painful narratives reflecting their struggles to remain with their problem drinker. This struggle involved trying to cope with increasing domestic burdens, often sole responsibility for their children, and seemingly, last of all, their search for their own happiness. Most had given up this 'balancing act' at some point along their drinker's path, and had continued their lives alone. This solitary journey, however, seemed tinged with considerable guilt, regret and thoughts of 'what if'.

Clinical evidence and alcohol-specific practitioners suggest that many PPDs appear motivated to help their drinker rather than leave them (e.g. Copello et al. 2000a+b; 2002). Consequently the current researcher was drawn to explore the phenomenon of PPDs who, at the point of interview, remained with their problem drinker. This decision may allow interpretation of some of the dilemmas that PPDs face in balancing concern for their selves, with concern for their drinker. The literature from both the co-dependency and psychoanalytic approaches to 'concerned others' resonates with these dilemmas, and foregrounds the often paradoxical outcomes of providing support for one partner independently of the other. For example, a number of researchers have investigated relationships between drink problems and marital satisfaction (e.g. Cranford et al., 2011; Halford and Osgarby, 1993; Kahler et al., 2003) or the roles that PPDs might usefully adopt in helping their problem drinker abstain from alcohol (e.g. Barber and Crisp, 1995; McCrady et al., 1999; Miller et al., 1999). Although such studies have generated valuable data suggesting complex reciprocal relationships between couples and/or value in helping the non-problem drinker to help their drinker, these investigations relied heavily on quantitative analyses leaving the PPD as a person almost 'invisible'. These studies also suggested paradox and dilemma – should a PPD accept or attempt to change the problem drinker, acquiesce or confront, detach or engage, support or 'punish'? Similarly, Copello et al (1996) emphasise exploring whether 'concerned other' have been acting in a tolerant or self-sacrificing manner in relation to their problem drinker. Such responses may be incompatible with personal growth, autonomy and independence, acting instead as 'obstacles' to well-being, or to self-actualising in person-centred terms. Such individuals might benefit from considering alternative options for coping, such as creating some 'distance', reducing responsibility for the problem, *self*-care strategies, all increasing a sense of agency. The

current study aims to place PPDs at the centre of this research and use their voices to describe and interpret their experiences, which may well include significant ambiguity. To the best of my knowledge, with the exception of Reid (2009), research with an exclusive qualitative focus on the lived experience of PPDs has not been done before.

Velleman and Orford, two of the most eminent and respected researchers into the impact of alcohol misuse on family members, have provided valuable qualitative insight into life with a problem drinker. However, both authors work within a so-called stress and coping perspective and have used their findings to develop alcohol-related coping strategies which stem from participant defined problem drinking. Whilst these are considered credible, valuable and consistent with people's lived experience, the current researcher aims to explore stress and coping in the wider context of life with a problem drinker. The rationale for a more encompassing approach stems from the recognition of potential links between stress and coping and related phenomena; specifically, mixed emotions, personality variables (notably optimism and pessimism), cultural factors, differential use of lay theories and beliefs about happiness and wellbeing. This expectation of rich, dynamic, complexity, suggests that from a counselling psychology perspective it may be useful to seek greater understanding of the phenomena derived from this potentially vulnerable group of people.

So, the current researcher, rather than aiming to support any particular theory, embraces Orford's (1984) belief that adherence to any one viewpoint restricts the outlook of professionals working with families affected by alcohol misuse. A more 'open' exploration might strengthen a 'whole person' coherence of approach for health care professionals and counselling psychologists working with PPDs.

Finally, it is hoped that a deeper understanding of the impact of living with a problem drinker on a partners' sense of well-being may encourage further development of person-focused therapy, and enable PPDs to develop better coping strategies pertinent to their own individual contexts and needs.

Chapter Two: Methodology

2.0 Research Aim

To explore the lived experiences of individuals who decided to remain with their partner, whom they identify as a problem drinker, and who may have faced challenges to both their psychological well-being and/or personal growth as a result of this decision.

2.1 Overview and Rationale

The research question is concerned with the subjective experience and meaning-making of partners of problem drinkers which necessitates positioning this study within a qualitative methodology. Interpretative Phenomenological Analysis (IPA) is chosen above alternative qualitative research methods given its concern with examining lived experience and how we make sense of such experience (Reid, Flowers and Larkin, 2005; Eatough and Smith, 2013). The current author argues that IPA is consistent with a range of philosophical, epistemological and ontological underpinnings whereby valuable research knowledge of partners of problem drinkers may be gained. Further IPA explicitly "offers psychologists the opportunity to learn from the insights of the experts, the research participants themselves" (Reid et al., 2005: 20); this resonates with the researcher's valuing and experience of person-centred practice.

The following sections provide my navigational route through the 'map' of philosophical and methodological stances towards my destination - presenting the analysed experiences of ten middle-aged female partners of male problem drinkers.

2.2 Rationale for Adopting a Qualitative Approach

A qualitative approach is seen as essential for exploring the subjectivities inherent to all aspects of the human experience and action under study in this research. Qualitative research primarily focusses on the investigation of meaning (Willig, 2012). More specifically it allows researchers to describe and/or interpret how individuals make sense of their world and how they understand phenomena in question. In essence qualitative researchers are interested in the quality and richness of personal lived experience.

The past thirty years or so has witnessed a substantial increase in qualitative research, which in turn has engendered vibrant dialogues between advocates of qualitative methodologies, not just in relation to their traditional 'adversaries' who endorse quantitative approaches, but within the qualitative community itself. In fact, contemporary qualitative researchers are confidently presenting a case for qualitative methodologies being the driving force for exploring human action and experience (e.g. Boyatzis 1998; Bryman, Becker and Sempik, 2008; Elliot, Fischer and Rennie, 1999; Harré, 1998, 2004; Holloway and Todres, 2003, 2007; Mason, 2006a+b; Nightingale and Cromby 1999; Parker, 2004; Willig, 1999, 2001, 2012, 2013; Yardley and Bishop, 2008) and evolving guidelines for quality criteria (e.g. Bryman et al., 2008; Elliot et al. 1999).

Harré (2004) for example succinctly presents reflexivity, meaning and specificity as the key concerns which allow qualitative research to be 'properly scientific', whereas traditionally quantitative methodologies, with more nomothetic concerns, are seen as the 'gold standard'. Specifically Harré argues that researchers need to reflect on the way claims are made about individuals from aggregated (often quantitative) descriptions of behaviour to provide insight into *being* human. A fundamental aspect of qualitative analysis is that it values subjectivity in its own right, rather than striving to reduce or eliminate it as in a post-positivist orientation; consequently this epistemological position views knowledge as inherently subjective (Langdridge 2013). Mason (2006a) also believes that qualitative methodologies have an 'explanatory edge', being more concerned with interpretation than causation, and are well-placed to facilitate 'a palette of methods' for the multidimensionality of peoples' 'real' lives. Specifically she argues that qualitative methodologies offer the 'logic of comparison' which facilitates contextual and cross-contextual explanations.

Similarly, Holloway and Todres (2007) believe that qualitative methods are well-suited to borrow from both art and science traditions to incorporate different types of knowledge (propositional, practical and personal) given their emphasis on meaning rather than

measurement and causation. They also believe that embracing such different forms and expressions of meaning are likely to enrich the 'core meanings' of research endeavours and allow readers to react more personally and emotionally with identified themes; being self-evident to the reader (Elliot et al. 1999).

All of these views appear consistent with both the current research question and an IPA approach.

2.3 Interpretative Phenomenological Analysis (IPA)

IPA was first articulated by Smith (1994; 1996; Smith, Flowers and Osborne, 1997) and viewed as a qualitative approach which moves "beyond the divide between cognition and discourse" (Smith, 1996: 261), thus positioning it between post-positivism and extreme relativism and 'strong' social constructionism (Willig, 2012). Since its inception an increasing number of researchers have viewed IPA as an evolving methodology, as highlighted by both its creators (e.g. Smith and Eatough, 2006; Smith and Osborne, 2007) and current IPA researchers (e.g. Wagstaff, Joeng, Nolan, Wilson, Tweedlie, Phillips, Senu and Holland, 2014). In this climate of flexibility and evolution, the current researcher postulates that the word "divide" is too 'strong' for more recent IPA positions in that it could be more usefully described as *facilitating a connection* between 'cognition and discourse' and other domains of mainstream psychology (see later). Notwithstanding this change of emphasis, locating IPA in an epistemological 'middle ground' location allows: the existence of a reality independent of the knower; an exploration of human cognition, particularly perceptions, thoughts and attention processes; an acknowledgement of the important role of language in making sense of and articulating our experiences; and the assumption that individual subjectivities are embedded within their personal, social-economic and cultural histories.

Smith (2004) emphasises IPA's specific approach as being defined by the three central features, namely: idiographic; inductive; and interrogative. In brief, IPA seeks to present interpretations of individual accounts (whilst being mindful of common themes) which are firmly embedded in the data, and interrogated with reference to the researcher's subjectivity. In this way IPA attends to all aspects of the lived experience, including feelings, motivations and beliefs systems, and how these might be expressed in behaviour and action (Eatough & Smith, 2013).

The focus on examining 'lived experience' and how we make sense of such experience highlights IPA's specific theoretical positioning within both phenomenology and hermeneutics respectively. Phenomenology, given the analytic focus of IPA is personal experience, and hermeneutics in that it also aims to interpret and understand participants' experience whilst explicitly recognising a central role for the researcher in this process. Further, in order for the researcher to both describe and interpret the participant's world, a double hermeneutic is involved:

> "The participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world." (Smith, 2004: 40).

The employment of a double hermeneutic is consistent with my considered stance as 'research instrument' and appeals to my beliefs and opinions concerning progress and practice within counselling psychology. For example, Strawbridge (2006: 13) highlights "the self as [counselling psychologists'] central resource [incorporating] significant demands made upon our self-awareness, ethical sensitivity and personal qualities or 'virtues'". This emphasis on the individual counselling psychologist's subjectivity 'mirrors' both IPA's 'double hermeneutic', and the central aim of this research to provide something of value to therapeutic endeavour, particularly for individuals who are enmeshed in their partner's drink problems.

This position will be elaborated both within this chapter and culminate with its evaluation in the synthesis and discussion.

2.3.1 IPA within a Phenomenological Approach

Giorgi and Giorgi (2013) describe the (transcendental) phenomenology, proposed by Edmund Husserl (1859-1938), which underpins IPA, as a method of allowing fundamental concepts within all scholarly disciplines to be presented rigorously such that it would provide a firm basis to each science. Husserl proposed that what humans experience represents the starting point of enquiry, thus rejecting the psychological presupposition that something more fundamental lies behind experience. Phenomenology examines humans' sense-making about the world around them by assuming that the context in which the experience takes place will affect the construals of the individual's reality. Moustakas (1994: 28), for example, suggests that the "self and world are inseparable components of meaning" so that the perceived world takes place within the parameters of an individuals' complex phenomenology. Hence, phenomenology attempts to describe the individual's

'frames of reference', highlight the qualitative diversity of their experiences, and extract their essential meanings (Kvale, 1996).

Willig (2012) explains that Husserl argued it was possible to transcend presuppositions and biases and to experience a state of pre-reflective consciousness which allows us to describe phenomenon as they present themselves; "to extract the 'essences' that give the phenomenon their unique character" (ibid: 84). To elucidate 'essences' however is considered too abstract as an underpinning *method* for exploring actual experiences. Accordingly, IPA draws upon the more contextualised, existential phenomenology of Heidegger as a phenomenological *methodology* rather than a philosophy (Giorgi and Giorgi, 2013; Smith, Flowers and Larkin, 2009; Wagstaff et al.; Willig, 2012). Similarly, Willig (2012) draws upon the writings of Spinelli (1989) who points out that phenomenological psychology is more concerned with the diversity and variability of human experience than the identification of 'essences' in Husserl's sense. Willig (2012: 85) also skilfully and succinctly 'translates' phenomenology from the philosophical enterprise of "introspecting on one's own experience" to phenomenological *research* in which "the research participants' accounts becomes the phenomenon with which the researcher engages" (Willig, 2012: 85).

A further problem with Husserl's original position is the impossibility of suspending all presuppositions. IPA researchers are urged to 'bracket' the phenomenon to allow them to engage in a critical examination of his or her customary ways of knowing (about) it. In the same way Langdridge (2013) posits that researchers' attempts to remain objective are flawed because it is inevitable that the subjectivity of the researcher will influence the analytical process in a variety of ways. By explicitly acknowledging the subjectivity of the researcher in the process of research provides the central anchors between IPA and phenomenological psychology; "it is only with the recognition of the active involvement of the researcher in the research process that understanding can truly emerge" (Langdridge 2013: 252).

2.3.2 Taking a Pragmatic Approach

Robson (2011) discusses how the quantitative paradigm, being rooted in positivism, is based on the assumptions that scientists could make objective, value and context-free observations of human beings. In other words, science has *direct* access to an independent reality. See Johnson and Onwuegbuzie (2004) for a valuable and readable account of the

argument for the post-positivist stance that a single, *directly accessed* independent reality is untenable.

Most scientific endeavours within a post-positivist paradigm endorse the so-called hypothetico-deductive model of scientific activity. This model incorporates Popper's (1970) notion of falsifiability whereby theories must generate empirically testable hypotheses for confirmation or refutation. This way of working allows scientist to continue to propose and establish general causal laws or theories. Willig (2013) however notes that despite the value of Popper's work, his lack of acknowledgement of the role of an individual's cultural milieu in knowledge formation precipitated challenges from advocates of qualitative methodologies. These challenges predominantly embrace a relativist position.

IPA however allows the researcher to 'unbracket' their wealth of psychological knowledge, including that derived from quantitative research, in the final stages of analysis; this aspect is endorsed and valued and is believed to hold greater relevance to counselling psychology as a result. Accordingly, the current researcher developed a model in the final chapter (Figure 4.1) which attempts to convey the academic, professional and personal subjectivity that was brought to the participants' narratives once 'brackets' had been 'removed'.

2.3.3 Relativism and 'Strong' Social Constructionism

This section elaborates the current researcher's decision to embrace qualitative methodology but without endorsing the extreme relativist assumption of infinite realities.

Relativism represents the belief that all knowledge can only be known by taking account of the subjectivity of the would-be knower. Willig (1999; 2001; 2012; 2013) describes extreme relativism with reference to 'strong' social constructionism as it assumes that what we perceive and experience is mediated historically, culturally and linguistically, therefore never a direct reflection of reality; it provides "'knowledges' rather than 'knowledge'" (Willig 2008: 7). In its extreme form it assumes that each individual constructs their own reality, which renders common patterns and a single independent reality illogical (Robson, 2011).

Edwards, Ashmore and Potter (1995) are viewed as some of the strongest advocates for a 'pure' social constructivist stance which is predicated on the dominance of language and discourse. Cromby and Nightingale (1999), themselves social constructionists, applaud the challenges that such social constructivists have made to traditional conceptualisations of phenomenon such as attitudes, memory, personality, emotions and the 'self' which were

seen as “qualities or properties *of* individuals” rather than as socially constructed *between* individuals” (Cromby and Nightingale, 1999: 6, italics added). These authors also greatly respect and admire what they call the most “forthright celebration of relativism [that] nothing ever has to be taken as merely, obviously, objectively, unconstructedly true” (ibid: 8). Despite embracing this central tenet, Cromby and Nightingale (ibid: 8) believe that a greater distinction needs to be made between “word and world”. They believe ‘strong’ social constructionism has evidenced an over reliance on language, part of the so-called ‘discursive turn’ from post-positivism, which is used to construct an infinite number of realities without recourse to an independently existing reality.

In sum, the reluctance of social constructionism to acknowledge the existence of an independent reality makes it incompatible both with the aims of this research and with the theoretical underpinnings of IPA. Like Williamson and Sacranie (2012: 115), the current author pays particular attention to the experiential elements of the participants meaning making of their ‘real’ world, whilst being open to ways in which “discourse resources and constructions [also] shape the accounts provided by the[ir] women”.

2.3.4 IPA and Critical Realism

Searle (1995) states that “realism is the doctrine that an external world exits independently of our representations of it” (cited in Cromby and Nightingale 1999: 6), which implies that a realist orientation allows human perceptions, thought and language to reflect an independently existing reality.

Bhaskar (e.g. 1979; 1986) and Harré (1998, 2004) have been particularly influential in advancing a critical realist approach whose central assumption is that human action is both meaningful and intentional, hence involves subjectivity. Consequently, Robson (2011: 35) argues that realist research necessitates “reflexive monitoring of conduct in a social milieu” which allows a causal role for agency traditionally ignored by objective approaches. Specifically, critical realist explanations focus on understanding the operation of mechanisms by exploring the complex, dynamic processes that link actions and contexts with mechanisms and their outcomes. Bhaskar (1979) notes the importance of triggering such mechanisms to ensure they are active as a vital precursor to empirical investigation; the current research recruited non-concordant (problem) drinkers to increase the likelihood of exploring adversity (e.g. Floyd et al., 2006). These views are consistent with Willig’s (2013) arguments for empiricism with its grounding in data and ‘facts from experience’. She believes that empiricism allows qualitative research to “move us closer to the truth” (ibid: 3).

2.3.5 'Light Constructionism' and Critical Realism

Eatough and Smith (2006: 485) described IPA "as taking a light constructionist stance in contrast to the strong constructionism of discourse analysis". Cromby and Nightingale (1999) noted that Edwards et al. (1995) had steadfastly maintained their 'strong' constructivist position despite consistent counterarguments. Since this time the number of researchers employing IPA methodologies has grown significantly (see: Reid et al., 2005; Eatough and Smith, 2013; Wagstaff, et al., 2014). While discourse analysis ('strong' constructionism) focuses on the way language constructs people's worlds, IPA puts greater focus on understanding and making sense of individuals' ways of thinking and being. Consequently, this blossoming of IPA research, with its experiential as opposed to discursive emphasis has done much to strengthen this so-called 'light constructionism' stance (Eatough and Smith, 2006).

The current research also endorses a 'light' constructivist epistemology which assumes that the 'lived world' is constructed by the individual as an example of subjective reality, whilst maintaining the belief that some elements of that reality are to some degree fixed and relatively enduring. In other words, 'light' constructivism recognises that people's lives, experiences, and conversations are contingent upon and constrained by their cultural language, but their stance also stresses the importance of cognition by suggesting that there is more to our lived life than historically embedded linguistic interaction. This position then assumes an independently existing reality beyond the parameters of discourse. In this way IPA can be seen as analysing possible relationships between thoughts, discourse and behaviour, without viewing these components as having isolated, separate functions.

Willig (1999; 2012) also gives consideration to the role of social constructionism in seeking to understand the explored phenomenon, but has tempered this stance by embracing critical realism. She argues that although a social constructionist viewpoint allows us to notice that there can be different ways of describing an event, it does not help explain "why things are as they are and in what ways they could be better" (Willig, 1999: 38). Willig also suggests that a social constructionist perspective does not dictate a relativist position. We do not have to argue that the social environment be reduced to a set of objective, external stimuli, as critical realism maintains that the particular social conditions that the individual chooses to appropriate, create his or her environment. This means that a certain objectivity of the social environment can be assumed alongside that which is unique and personal to each individual (Willig, 1999); a pragmatic position.

Willig (1999) also argues that gaining an understanding social structures allows possibilities for future action. Therefore an epistemology which embraces not only what participants' experience, but also contextualises these actions within a stance that allows us to explain the present, also creates future potentialities. Accordingly, this research may offer counselling psychologists an understanding of the experiences of particular participants and also some suggestions as to how actions may be contextualised within different social frameworks, hence provide predictions for clinical practice.

2.3.6. Embodiment, Materiality and Power

Wiillig (1999, 2012) and Cromby and Nightingale (1999) argue that ('strong') social constructionism has paid insufficient attention to issues of embodiment, materiality, and power, "what we call, for the sake of convenience, the 'real'" (ibid: 3). It is felt these aspects of 'lived experience' are absent or under-emphasised and importantly, believe these aspects of human life are, "not reducible to discourse" (ibid: 3). These criticisms are consistent with Harré (2004) who believes that there is a 'world' (reality) beyond the social discourse that forms the main-stay of social constructivist knowledge claims. These arguments chime with conceptualisations of language as a pragmatic tool for allowing people to navigate their everyday realities (e.g. Allport, 1946) and the feminist material-discursive-intrapsychic stance taken by Ussher (1998) in relation to 'living with drink'.

Robson (2011) furthers the navigation towards a suitable methodological stance for the current research by arguing that human reality predominantly consists of social structures which are the relatively enduring product of human action and language. However, these pre-existing social structures are also conceptualized as the 'medium of motivated human action' thereby allowing an integration of objectivist and subjectivist approaches. Such assumptions allow my participants to perceive and construe reality to suit their purposes. Accordingly, participant construals, as mentioned earlier, will be discussed in relation to a seemingly wider incorporation of my subjectivity than is apparent in the 'original' methodological guidance provided by Smith (1994; 1996; Smith et al., 1997); including within my substantial knowledge of psychology and counselling psychology. Further, the analyses in this current research will benefit from an increased the level of critical ('suspicious') interpretation as espoused by the contemporary writings of Willig (2012); explored in the next section.

Dumont (2010) notes that Allport (1937 [1961]) argued that the mind is an active agent "addicted to rational problem solving, and bent on manipulating sensory data according to

its own inherent nature" (Dumont, 2010: 8). Consequently he favoured methods with 'idiographic intent' such as case studies and interviewing as he believed they "contrive to keep together what nature itself has fashioned as an integrated unit – the single personality" (Allport, 1946: 133). Allport's assumptions provide part of the foundation for my decision to analyse the interview data using IPA, as this is consistent with exploring meaning and function within my participants' phenomenological worlds. Allport's views are also arguably consistent with a realist epistemological stance.

2.3.7 The Role of Interpretation in Qualitative Research and IPA

The phenomenology aspect of IPA seeks to set aside assumptions and describe the phenomena by immersing oneself in the phenomena until its essential features are revealed. The hermeneutic aspect however, assumes that understanding is a matter of interpretation. In other words, using an IPA method necessitates the incorporation of interpretative processes.

Willig (2012: 5) believes that "interpretation, in its most basic sense, refers to the construction of meaning [and] is concerned with elucidation, explanation, and understanding" of phenomenon. Specifically IPA analyses interpretations from articulations of the 'lived experiences' of participants or 'phenomenal experts' in conjunction with interpretations offered by the researcher. These co-construed interpretations are the essence of IPA's double hermeneutic; the researcher 'asks' what does the participant *mean* about their experience, then what does that mean for the researcher through the veil of their subjectivity.

Willig (2012) posits that in everyday life individuals give meaning to things that happen very quickly without being aware, or with little conscious thought or deliberation. In other words she believes that often individuals may be unaware of their meaning making or importantly alternative meanings. Using IPA the researcher is able to analyse possible meanings in a conscious and considered fashion *and* offer alternative meanings. Facilitating the analysis of alternative meanings would be extremely useful in a counselling context.

Willig (2012) also believes that at times, everyday interpretation is a much more conscious activity, particularly when people are experiencing situations where meaning is ambiguous or uncertain, "where we have to actively work out what is going on" (ibid: 5). Again IPA's double hermeneutic can be instrumental in exploring experiences that participants may find difficult to elucidate, thereby strengthening their voice. It is these 'deliberate' interpretations

that Willig (2012) is most concerned with, as they occur in situations which are both important but also those in which meaning is uncertain. Again analysing such ambiguous situations such as those encountered by PPDs is likely provide insight for providing more functional interpretations for interventions with clients. For example, all major approaches to counselling intervention are predicated upon gaining understanding and empathising with the client, in other words interpreting their difficulties in a way which may lead to positive change and growth. Accordingly, Chapter Three, Findings and Analytical Dialogues, can be viewed through the 'lens' of the researcher as a counselling psychologist exploring a range of possible interpretations of the 'lived experience' of the PPDs. These largely referenced interpretations may give impetus to practitioners and counsellors working with alcohol problems in family settings.

Willig (2012: 10) proposes that "the type of interpretation we generate depends upon the epistemological position we adopt before we start the process of interpretation". Willig (2012) describes two differing orientations to the interpretative task; namely those characterised as interpretation driven by 'empathy' and by 'suspicion', as in 'get to the truth of the matter' (Ricoeur, 1970; Langdridge, 2007)

'Empathetic' interpretation "seeks to elaborate and amplify the meaning that is contained within the material that presents itself" (Willig, 2012: 13). In other words the interpreter merely focuses on what is manifest as opposed to 'hidden'. 'Suspicious' interpretation "aims to unmask that which presents itself, to bring out latent meaning which is contained within but which is not immediately obvious or which is actually obscured by appearances" (Willig: 2012: 12). Suspicious interpretation tends to be theory-driven such that the theory, for example, Freudian psychoanalysis, provides the 'lens' through which data is read. Currently this approach is being termed a 'grand theory' approach where the value and validity of inherent concepts from these theories is presupposed. The current research embraces 'suspicious' interpretation and theory (grand or otherwise) in a way that represents a departure from a predominantly 'empathetic' interpretation apparent in early evolutions of IPA (Smith, 1994; 1996; Smith et al., 1997); although by 2007 Smith (Smith and Osborne, 2007) encouraged individual departures, of which this is one.

According to Ricoeur (1996, cited in Willig, 2012) empathetic and suspicious interpretations produce different kinds of knowledge, concerned with understanding and explanation respectively. Further Ricoeur points out that neither of these two interpretative positions on its own can generate satisfactory insight and that a combination of the two is required; this conclusion is embraced in the current research.

2.4 Rejection of Alternative Qualitative Methodologies

Alternative qualitative methodologies were carefully considered but ultimately rejected.

Methodologies which define categories of meaning *before* data analysis is performed (such as content analysis and to a lesser extent thematic analysis) were rejected because the researcher did not wish to constrain the findings by imposing pre-defined categories.

Discourse analysis (DA) for example Potter and Wetherell (1987) is grounded in a 'strong' social constructionist epistemology which sees knowledge and reality as socially, culturally and historically constructed, as well as fluid, uncertain and dynamic. Specifically, DA espouses a discursive approach to psychology in which language constructs reality rather than reflecting it. A 'light' constructionist position, as previously discussed is considered more appropriate. In other words, DA was considered as incompatible with the critical realist stance as argued above. This rejection does not however represent a rejection of the importance of discourse, merely acknowledges that linguistic interaction is not the main focus of this research.

The most suitable qualitative methods allowing exploration of the experience were identified as Interpretative Phenomenological Analysis (IPA) and grounded theory. Grounded theory (GT; Glaser and Strauss, 1967) is both a means of generating theory and a set of techniques for conducting qualitative research. Payne (2007) describes certain criteria for situations where GT would be suitable as a research technique. Although the current study does embody some of these, for example it is exploratory, and aims to elicit participants' experiences it does not meet several others. For example, GT is deemed suitable when there are no 'grand' theories to explain phenomena under investigation and when researchers wish to develop theory. Alternatively, when theories exist, GT is a suitable technique to challenge or replace them (Payne, 2007). In some ways GT is closest to the epistemological needs of this research which does not rule out the evolution of new theory or the eventual replacement of others. However, the main aim here is to understand and interpret the 'lived experience' of partners of problem drinkers, rather than develop a theory per se. Also, this approach does not place the researcher role or subjectivity in such a prominent position as IPA.

In contrast, IPA acknowledges that the researcher is involved with the research process and that this involvement will both inform and influence each stage of the research process (Willig, 2012; 2013). It appeals to the current researcher to bring her knowledge of

psychology, counselling, experience as a partner and life experience generally to the task of analysing the rich and multi-faceted data. Its emphasis on reflexivity allows the possibility for genuinely creative exploration of the participants' subjectivity as long as this remains connected or 'true' to the meaning-making provided. This position also allows the integration of valuable pre-existing theoretical and empirical knowledge in the deeper interpretive phases.

In sum, IPA was considered to be most suited to the current study, as the researcher was aware of having a particular interest and position with regard to partners and wanted this to be explicitly acknowledged and reflected upon throughout the process.

2.5 IPA: Procedures and Exemplars

The procedure was guided and informed by its first articulations by Smith (1994; 1996; Smith, Flowers and Osborne, 1997), later descriptions of the analytic procedures, again by Smith and colleagues (e.g. Smith and Eatough, 2006; Smith and Osborne, 2007), by navigating the choices and considerations of previous IPA researchers (notably, Flowers and Buston, 2001; Williamson and Sacranie, 2012; Wagstaff et al. 2014; Gubi and Marsden, 2013; Shineborne and Smith, 2009), and by incorporating aspects of good practice within qualitative research, and more specifically by the valuable stages and exemplars provided by Willig (2013). These various sources of support provided the confidence and 'permission' to work in ways that ensured the "integrity of what the participants said [was] preserved as far as possible" (Smith and Eatough, 2006: 328) and was consistent with my subjectivity and experience. In other words, IPA's 'double hermeneutic' maintained a central role throughout and supported my confidence to be mindful of what I brought to the interpretative processes, both personally and academically. I also accept the importance of an on-going reflexive dialogue on the part of the researcher throughout the analytic process and the need to make this explicit. Providing valuable reflexivity involves a consideration of the subjectivities that are embraced within qualitative methodologies. I have provided key aspects of reflexivity of the analytical stages as part of the IPA 'Paper Trail' (Table 2.1).

The cumulative flexibility of guidance above, and Smith and Osborne's (2007: 54) statement that "there is no single definitive way to do IPA" allowed the current researcher some degree of departure from original conceptualisations of IPA. Firstly, whilst retaining empathetic interpretation, greater interpretative scrutiny ('suspicious' interpretation, Willig, 2012) was included; as outlined in Section 2.3.7. Accordingly, throughout the analyses I

tried to acknowledge my active, critical, selective, and meaning-making role. Secondly, I felt emboldened to make some changes from the 'four stage process' outlined by both Smith and Eatough (2006) and Smith and Osborne (2007) to allow a full analysis of each participant before an extended and iterative process of theming; see below.

IPA is an idiographic approach and at its inception involved a detailed examination of one case, which continues, following an iterative process, until some degree of understanding or 'gestalt' is achieved (Smith, 2004). Each case is treated to the same rigorous examination, followed by a gradual and then more systematic cross-referencing. The aim is the integration of common themes, whilst still allowing for difference across more common themes. The analytical strategy adopted in the current retains the idiographic and iterative approaches but applies them equally to each of the ten accounts. In other words the first participant's story is incorporated with the remaining nine and theming and clustering stages involve all cases. Smith and Eatough (2006: 328) acknowledge that "researchers adopt various strategies to organise and condense themes".

Braun and Clarke (2006) note that no theme can be entirely inductive or data driven as the researcher's knowledge and preconceptions will inevitably influence all stages of theme development from identification through to write-up. Additional guidance includes: rejecting size of a theme as a sufficient criterion for substantive value, consistent with the idiographic nature of IPA; considering co-occurrences or sequencing; balancing breadth and overlap with specificity; "new insights can often be provoked by what appear to be anomalies" (Braun and Clarke, 2006: 64), which is consistent with Joffe and Yardley's (2004) suggestion to take counter-evidence seriously by keeping a 'model of testing' (as with statistical tests) in mind.

2.6 IPA: Analytic Strategy

Willig (2013) outlines the phenomenological method of gaining understanding as involving three distinct phases of contemplation (referring to Moustakas, 1994) namely: epoché; phenomenological reduction; and imaginative variation.

The first phase follows the 'rule of epoché' (developed by Spinelli, 1989) and requires the researcher to suspend suppositions and set aside or bracket initial biases and prejudices in order to be open to the experience offered by each participant. This openness is aimed at facilitating greater accuracy in recognising, describing and then interpreting the participant's experience. This iterative process commenced after each interview, and initial thoughts,

feelings, and reactions around 'what was going on for the participant' were noted in a journal (see Table 2.1) Often this contemplation would involve reflecting on how the participant might view the researcher, and how particular questions and prompts might have shaped the narratives. Unfortunately it is not possible to do complete justice here to this thought-provoking early stage of IPA.

Commencing the IPA analysis 'proper' involved transcribing all interviews, then reading, rereading and familiarizing myself with the data (emersion). Hammersley's (2010) distinction between reproducing and constructing during the process of transcribing guided my efforts to present the data from the participants' frames of reference; although this will not have been 'perfect'. However, every interview was written verbatim, with pauses, repetitions, tone of voice and so on to provide maximum detail and context for subsequent description, analysis and interpretation.

Completed transcripts are usually placed with generous margins on both sides, one for initial comments "which capture the participant's experience [on] on first encounters with the text" (Willig, 2013: 87); the other for potential themes. These comments embraced Husserl's second rule of phenomenology, the rule of description. Spinelli (1989) suggests that the essence of this rule is to describe, not explain. Although, as suggested by Willig (2013) and Smith et al. (2009) these comments need to be primarily 'descriptive', they can also include reflections on 'linguistic' and 'conceptual' observations and notes that reflected initial thoughts, links, questions, absences and so on. These interpretations and 'commentaries' of the interviews were hand-written (primarily in my journals) as Hammersley (2010) argues this labour-intensive process is conducive to reflexivity and considered decision-making. The iterative nature of IPA meant that there was no definitive end to this process.

The next stage involved re-reading the transcripts in order to identify and label emergent themes. Where a similar theme was noted more than once, each occurrence was given the same theme title. Again this early theming was hand written and separate pieces of paper were used for each emerging theme; a further departure from IPA's original analytic strategies. I found it helped to 'collect' themes together in this way in order to gain insight into emerging patterns; I note similar 'variations', or additions in my case, appear in contemporary IPA papers (Wagstaff et al. 2014).

Husserl's third rule is the rule of horizontalisation, which requires the researcher to treat each descriptive element of equal importance. Consequently I resisted the temptation to

contemplate hierarchies in the early stages of analysis. I aimed to examine the participant's experiences with as open a mind as possible. When the entire transcript had been systematically analysed in this way these early emergent themes were reviewed and grouped or linked according to their apparent meaning for the participant. All transcripts were analysed in the same idiographic manner, although increasingly links across participants were presenting themselves. Willig (2013) gives 'permission' for psychological terminology to be used at this stage whilst remembering that the themes need to "capture the experiential quality of what is being described" (ibid: 88). For example, 'appealing to Dr Jekyll', 'being mother' and 'self-preservation' formed a cluster of 'Coping', which resonating with both alcohol-specific and mainstream conceptualisations of coping. As mentioned previously, this represents a greater inclusion of a priori theory and evidence, but only after the emergent themes have been thoroughly grounded in the participants representations of their 'lived experience'.

The third stage represents an attempt to introduce structure into the analysis and the researcher lists all the themes from the individual analyses and contemplates them in relation to each other. Specifically some themes will share meaning or references, some suggest links and hierarchies, others suggest different perspectives, functions, and in the case of this study, different 'locations'. Specifically there was strong sense of a journey (similar to Flowers and Buston, 2001 and Gubi and Marsden-Hughes, 2013), the 'drinker's path'. Theme clusters gradually suggested differing stages such as 'counting blessings' before the drink problem started and 'revisiting responsibility' post 'rock bottom'. Willig (2013) states the importance of clusters making sense in relation to the original text. This requires the researcher to move back and forth between the themes that are being constructed and the original text to ensure that the emerging connections are grounded in the data.

The fourth stage of the analysis recommends the production of a summary table showing the clustered themes, with quotations by way of illustration of each theme (Willig, 2013); in IPA's original form the summary table would have been made for the first participant only. Willig (2013) reminds the researcher that integrative higher order themes must be grounded in the data, in the same way as lower level themes. Therefore emerging superordinate themes were checked against the transcripts. At this stage a decision was made on which themes from stage two (or beyond) should be discarded (as failing to capture the essence of experience or marginal to the phenomenon), and which would be further validated. The result of this integration was an emerging table of master themes and clusters of sub-

themes, with illustrative quotes from participants; see Table 2.1 for location of stage four tables.

The final stages of theme development involved the following: reviewing all resulting themes for consistency (using a test-retest reliability rather than inter-rater reliability) and validity (using literature, my interpretations, supervisor's comments and a number of 'validity checks' by adult students who had lived with problem drinkers) and reviewing and entitling superordinate and subordinate themes with reference to the research question.

Once the table of superordinate themes had been created, the process of writing-up the analysis was begun. This aimed to provide a narrative account of the participants' experiences, seeking to explain and illustrate the themes, but also to interpret the findings and link these to the existing literature.

I kept reflective journals of all aspects of the journey or 'adventure' (Willig, 2001) from the interview stages to the final write-up; an endeavour I found enormously enjoyable and valuable.

Aspect of Paper Trail	Location
Extracts of original transcripts	Appendix 2
Extracts of early theming – reflections on adjustments	Appendix 3
List of early / original themes and commentary adjustments	Appendix 4
Early theming diagrams showing initial connections and associations	Appendix 5
Extracts of later theming using right and left hand margins.	Appendix 6
Journal extracts (various) on the process and reflexivity	Appendix 7
Examples of later diagrams from last stages of the IPA process	Appendix 8
Exemplar / Reflexivity Table showing the main issues, dilemmas, tensions and resolutions	Appendix 9

Table 2.1: IPA Paper Trail

2.7 IPA and Quality Criteria

The growth in qualitative research (as noted in section 2.3) has been heavily responsible for raising questions concerning the appropriate quality criteria for use in all research endeavours (e.g. Bryman et al., 2008) and the publication of qualitative research (e.g. Elliot et al., 1999). An e-survey by Bryman et al. (2008) revealed strong preferences for the traditional criteria of quantitative approaches, namely, validity, reliability, replicability and generalizability to be restricted to quantitative research; although validity and reliability were also considered as valuable quality indicators for qualitative research, by 76% and 57% of the respondents respectively. Quantitative approaches commonly endorse the criteria devised by Lincoln and Guba (1985), namely, credibility, transferability, dependability and confirmability, although there appears far less consensus on their relevance to qualitative research (Bryman et al., 2008). Given this somewhat ambiguous 'guidance' the current researcher aimed to comply with a 'collective endorsement' of good practice predicated upon transparency and rigor of process; seemingly universally agreed (Bryman et al., 2008). Similarly, Robson (2011) argues that the term 'reliability' requires re-conceptualising in terms which are appropriate to qualitative research and suggests that this re-framing might include a transparent audit trail which allows others to gage the extent of the thoroughness and honesty of the researcher's endeavours.

The audit trail for the current research began by explicitly engaging with the philosophical, epistemological and ontological underpinnings of this particular evolution of a 'standard' IPA approach (e.g. Brocki and Wearden, 2006; Reid et al., 2005; Smith et al., 1999; Wagstaff et al., 2014; Willig, 2013) which were provided in sections 2.3 to 2.7 inclusive. IPA was described by its three key domains of philosophy of knowledge, phenomenology, hermeneutics and idiography, and these guided the different emphases and suggested techniques suitable for the exploration of 'personal lived experience' (Smith, 2004). Further, Langridge (2013) argues that qualitative research is almost always naturalistic and concerned with the quality of a phenomenon and identifying processes rather than quantifying variables and predicting outcomes. No attempt was made to control 'extraneous variables', for there can never be extraneous variables (which might impose a particular way of seeing the world) in qualitative research, "the noise is part and parcel of the phenomenon and to (attempt to) exclude it from an investigation is to lose the essential richness of a person's experience" (Landridge, 2013: 260).

This research is also premised on the universal human tendency to use everyday language to describe, explain and predict an individuals' own actions and those of significant others

(Dumont, 2010), in this case the experiences of living with a problem drinker. Filippopoulos (2009) suggests that the only way that the truth can be studied is through personal experience; “even if the existence of truth is argued, then the only thing left to study is the personal accounts of the truth or the personal perception of that ‘so-called’ truth” (ibid: 6). Similarly, Flowers and Buston (2001) posit that IPA is primarily interested in the subjective meaning people ascribe to events rather than attempting to record and represent objective events. In this qualitative study then the mediation of subjectivity is embraced, both in the ‘lived experience’ of the participants, and within the analysis of the researcher as the vehicle for interpreting meaning-making and understanding.

The above acknowledgements do not mean however that qualitative knowledge is less precise or less valid, as like quantitative research it is derived from systematic, rigorous and transparent criteria for ensuring quality in research as a scientific endeavour (e.g. Bryman et al., 2008). For IPA, the mainstay of its systematic approach to idiographic enquiry is the requirement of examining “each case in great detail as an entity in its own right” before more general claims are made (Osborne and Smith, 2006: 217). Further, knowledge claims in qualitative research hinge upon the transparency which is largely achieved through researcher reflexivity during the entire research process. Willig (2013) makes a valuable distinction between personal (see later) and epistemological reflexivity which is adopted in this research. According to Willig epistemological reflexivity encourages researchers to consider how the research questions, epistemological stances, and methodological choices have influenced assumptions about the participants’ world and the type of knowledge gained. Similarly,

> “All knowledge is knowledge of answers to specific questions” (Hammersley, 2010: 559)

The current researcher starts the process of reflexivity in the overview to this portfolio by revealing some important pre-conceptions, expectations and ‘drivers’ before the study commenced, and offers further reflexivity in relation to all others aspects of this research in what follows.

All interviews were conducted in a ‘person-centred milieu’ as this allows the participant to be the expert in their own phenomenology and respects their autonomy and agency. This approach forms an important part of this researcher’s private practice and was designed to elicit deep, rich personal data in a safe environment. The participants were asked the same standard questions to further validate the interview process; they were not leading questions so still allowed for individual differences to emerge. Flowers and Buston (2001)

acknowledge that in-depth interviews can directly harness the individual's propensity for self-reflection and narrative construction. The semi-structured interviews will however have been influenced by the researcher through the formulation of the questions, the prompts, requests for clarification and, of course, by her particular subjectivity in dynamic interplay with that of the participants.

The process of transcribing the interviews also raises issues of validity of knowledge claims by virtue of IPA's 'middle-ground' epistemological position (between post-positivism and social constructionism) which acknowledges a balance between the assumption of 'givenness' (from reality) and construction within the data (Hammersley, 2010). The current research places much emphasis on a manifest interpretation of what is being communicated, which would not be possible without the assumption of 'givenness' of an external reality that is being communicating about. Hammersley (2010) also suggests that even the verbatim transcription of interviews, as in this study, will involve a degree of construction rather than merely reproducing what is given. Consequently any conclusions reached are open to error, and the researcher's assumptions about human beings. However,

> "We must take care not to become prisoners of particular metaphors (givenness or construction) but rather assess what each can teach us about the process we are trying to understand" (ibid: 565).

Of necessity the analytical and theming stages of IPA require the researcher to be transparent about their assumptions of human *being* (ontology) of their participants. This researcher, like Landridge (2013) highlights the active nature of human beings and the complex ways in which they interact with and change their phenomenological worlds (also, Harré and Bhaskar). Allport (1946) firmly endorsed 'personal significance' as a crucial ingredient in understanding a person's response to their world, making this process highly subjective. Similarly,

> "The essence of the idiographic method is that it focuses its glass on the universe of behaviour traits *co-functioning* as a universe" (Beck, 1953: 356, italics added).

IPA also explicitly acknowledges the researcher subjectivity and its active role in interpreting the participants' interpretations of their 'lived experience' as embodied and en-cultured beings (e.g. Reid et al., 2005); this encompasses IPA's double hermeneutic. These interpretations may be drawn from a range of theoretical perspectives provided that they are inductively and firmly grounded in the participants' experiences, their phenomenological world. Willig (2012) elaborates on this position and posits that the researcher makes the

data meaningful and "therefore adds meaning to the data" (ibid: 6). Again reflexivity is vital as it,

> "urges us … to explore the ways in which a researchers' involvement with a particular study influences, acts upon and informs such research" (Nightingale and Cromby, 1999: 228).

Evidence of the researcher's subjectivity and its potential role in meaning-making is presented in personal reflexivity (Section 2.9), the analysis of findings (Chapter 3), synthesis and discussion (Chapter 4) and from extracts of personal research journals (see Table 2.1).

Finally, openness to reader evaluation is considered to contribute to reliability by the extent to which the study adds to the reader's understanding of the phenomenon (Madill, Jordan and Shirley, 2000). I welcome the views of the reader as to whether my research has resonated with his or her own quality assessment criteria.

2.8 Personal Reflexivity

> "Reflexivity urges us … to explore the ways in which a researchers' involvement with a particular study influences, acts upon and informs such research" (Nightingale and Cromby, 1999: 228).

Willig (2013) defines personal reflexivity as concerned with exploring the nature and influence of the researcher's subjectivity and ways in which this might reflect and be reflected by the participants' subjectivity. Similarly Larkin et al. (2006) argue that,

> " … any discoveries that we make must necessarily be a function of the *relationship* that pertains between researcher and subject-matter" (ibid: 107).

Bott (2010) believes that personal reflexivity prevents researchers being 'absent' or 'above' their research and will inevitably lead the researcher to identify/disidentify, like/dislike, familiarise/otherise within a dynamic process. Sollund (2008) for example, explores and reinterprets her own sympathy and antipathy towards two interviewees (murderers who took very different stances to their crimes). She candidly acknowledges that 'Yusef's' apparent lack of remorse drove *her* dislike, which on reflection could be reinterpreted as *his* denial in a process of self-protection. Similarly Grenz (2005: 2098) conceptualises power as a 'fluid process' operating between researcher and participant, therefore not *possessed* by anybody. She also believes that "stories are not only told for the listener, but also for one's own self-assertion". Reflecting on such intra and inter-subjectivities reminds us that

judgement is a subtext in any interview (Owens, 2006) and requires the investment of 'emotional labour' (Dickson-Swift, James, Kippen, and Liamputtong, 2007; 2009) to manage often strong emotions.

Willig (e.g. 1999; 2001; 2008) presents well-formed and energising arguments for embracing subjectivity within the 'adventures' she sees as inherent within qualitative methodologies. I now present something of my adventure

As mentioned at the beginning of the portfolio, my interest in exploring partners' perspectives with a view to therapeutic intervention partly stems from my experiences of living with a partner with health problems. These were brought into sharp focus when he suffered a heart attack on a family holiday in Italy, which required open-heart surgery. What was planned as a three-day trip to Pisa became a five-week sojourn during which I made two emotional farewells to Steve in case I never spoke to him again. This was a lonely and isolating experience, as despite a supportive network of family and friends I felt no one really understood my partner perspective. Well intentioned friends and family would ask, "How is Steve?", but would often end the conversation without asking how I was. Contemplating these experiences lead me to think about others in similar situations, to reflect on my relationship with Steve, and to wonder how I had managed to regain my positivity and zest for life.

In relation to this research I believe my experiences as a middle-aged female 'concerned partner' (albeit not one with a drink problem) fostered inter-subjectivity based on this common ground and mutual respect; part of an insight-enhancing 'sameness'. I, like my participants, had lived a life with periods of great happiness, but also significant adversity.

There were also important aspects of 'otherness' however, which will have affected the process dynamics of the interviews, and my eventual analyses, interpretations, and reporting of the findings. For example, I believe that I conveyed a deep respect to my participants and an understanding of some of the rigors of being a middle-aged partner, but was also conscious of being viewed as a woman training for a doctorate and working as a counselling psychologist. These 'facts' of my subjectivity convey a sense of power, status and purposeful endeavour. Also of note, I have never experienced any level of domestic violence or abuse, so needed to exercise 'extra' caution in my attempts to interpret these aspects of the women's experience. In sum, the inter-subjective dynamics will have evolved in different ways with each participant, some of which are explored later.

2.9 The Design: Procedures

2.9.1 Pilot Work

Six pilot interviews were conducted with middle-aged participants who lived with a partner with a health problem. The main purpose of the pilot work was to hone semi-structured interview skills whilst developing and maintaining a professional rapport. It was possible to ask the pilot participants directly whether they thought the interview felt conducive to revealing 'rich', personal, potentially sensitive material; they were well-known and trusted to be honest and constructively critical.

2.9.2 Recruitment

All participants are best described as self-selected. Eight were initially contacted from the databases of a variety of alcohol support organisations. This meant that organisation managers could phone potentially suitable participants and refer directly to the issue of living with a problem drinker. The managers had already been briefed about the project and they were able to explain the main research details. The managers passed on the contact details of all individuals who were willing to find out more about my project. Telephone contact was made with all potential participants and they were asked if they still wished to consider taking part in the research. If yes, selection criteria were checked and a brief outline of the project given (they were assured of full written documentation at interview). Interviews were arranged accordingly.

The remaining two participants comprised one recruited through a personal contact and one who responded to my advert on an alcohol support website (Adfam) which they had approached for help in living with a problem drinker. These participants were not asked directly so again were considered self-selecting. The same contact procedures were used.

2.9.3 Sampling Considerations

Ten participants were recruited which was considered an appropriate number to allow the analysis to present a balance between individual and common themes; although one participant has also been considered suitable (notably Shinebourne and Smith's, 2009, analysis of a recovering female alcoholic).

The **selection criteria** were as follows:

First and foremost the participants were *partners* of individuals whose drinking habits gave them cause for concern. Velleman's (1992) definition was adopted (see Chapter 1) as this is based on individual's perceptions and evaluations rather than objective measures such as units of alcohol and/or diagnostic labels such as alcoholic. These partners did not report or appear to be problem drinkers, and this non-problem drinking status was also confirmed by the alcohol support agencies (for eight) and self-disclosure to a third party for the remaining two. Neither partner had any major health problems (apart from those associated with problem drinking) as far as they are aware.

More specifically, problem drinking had been an issue for the participant for a least a year as the participant may be inclined to consider benefiting from sharing their experience rather than so heavily involved in making sense of the experience (Davis, Nolen-Hoeksema and Larson, 1998). The problem drinker could be at any stage of their drinking path as long as problem drinking was an important consideration for the participant. Middle-aged participants (40 – 70) given empirical and demographic evidence regarding significant benefits to 'extending' this life-span period (Allen, 2008; Brennan et al. 1994; Herzberg et al., 2006; NICE, 2005; Robinson, 2014: Robinson and Smith, 2010; Robinson and Stell, 2014) and difficulties of recruitment. The partner would be male or female from a heterosexual partnership, for homogeneity of sampling purposes. The drinker is the participant's sole partner and they are currently living together. The couple needed to be born and continuously resident in the UK as cognitions, meta-cognitions and hence interpretations are seen to be influenced by cultural variation (e.g. Cheung, 1997).

Interviews took place in: the participant's home, the researcher's home, rooms provided by local Al-Anon groups and local support group offices.

Table 2.2 below provides a summary of the participant's key biographical data.

Names of Participants (ages)	**Partnership details**	**Current status of the Drink Problem**
Ruby and Ray (60) (61)	43 years (married 40)	Still drinking, Dr diagnosed Ray as alcoholic.
Denise and David (49) (48)	21 years (married 20)	In-recovery, 6-months.
Beverley and Ben (43) (42)	5 years (not married)	In-recovery, but Beverley suspects occasional drink
Christine and Colin (55) (59)	35 years (married 34)	In-recovery, 16-months, 4 previous relapses.
Mary and Martin (50) (51)	25 years (not married)	In recovery 18-months
Olivia and Oscar (48) (50)	36 years (married 24)	In-recovery, 4 and ½ years.
Gemma and Greg (53) (47)	11 years (not married)	In-recovery, 2-months
Sandra and Simon (68) (51)	12 years (not married)	In-recovery, 5 years
Heather and Henry (59) (60)	25 years (not married), separated (2 years), 13-years ago.	In-recovery, 10 years
Fay and Frank (63) (65) {Fay, 1; Frank, 2, all grown-up}	30 years (married 13)	In-recovery, 12 years

Table 2.2: Biographical Information for the Ten Participants

2.9.4 Interviews: Descriptions and Procedures

A face-to-face, one-to-one interview was conducted with each participant. These interviews were semi-structured which allowed pre-determined questions to be responsive to the evolution of each interview.

Interview schedule is given in Appendix 10

Before any interviewing took place the project was explained, which included a summary of the participant commitments. The Participant Information Sheet (Appendix 11) was given and any participant questions answered as appropriate. Once the Informed Consent Form (Appendix 12) was complete and there were no further questions a digital voice recorder was turned on and the interview began.

The Biographical Information Sheet (Appendix 13), which was restricted to questions of direct relevance to the research, was completed. The participant was not asked whether their partner was still drinking, allowing this detail to evolve from the interview.

The first question ("How did you meet your partner?") was designed to reduce tension by having little direct relevance to problem drinking. Owens (2006) considers it important to build rapport at this first personal contact and accept the responsibility to 'expand the space' of the interview so that the participant may recount difficult experiences with ease. The remainder of the questions were asked as and when appropriate and in the main followed the participant's narrative flow.

The main focus of the interview consisted of attempts to elicit descriptions of predominately drinking-related events in the participant's life. The questions concerned: the drinkers' path and the partners' responses (actions, thoughts, emotions); particular events, incidents and occasions as appropriate; issues of responsibility; considering the future; current levels of discussion about the drink problem. The participants were provided with encouragement and prompts, and requests elaboration and/or clarification where necessary; although these were as 'neutral' as possible to reduce leading the participant or distorting their narratives.

The interview 'proper' took approximately one hour. I remained vigilant to signs of discomfort, distress or fatigue and gauged ending the interview at a suitable 'safe' place.

To end I asked if they felt all right and answered any further questions. I also thanked them again for their participation and giving my assurance that I would endeavour to do justice to the experiences they had shared.

2.10 Ethical Issues

Ethical issues were considered from the outset and formed a compulsory part of the research proposal (Appendix 14). I accepted a personal and professional responsibility as required by the codes of ethical conduct, which govern my practice as a counselling psychologist (B.P.S.; DCoP; HCPC) to consider the impact, implications and consequences of taking part in this project.

This research involved exploring a personal and potentially distressing area of my participants' lives, requiring a balance of my needs for research data with the needs and rights of potentially vulnerable individuals. Domestic abuse for example, might feature in my participants' accounts and trigger distressing thoughts and predictions. Experience of counselling and supervision (particularly in bereavement settings) lead me to believe that I was unlikely to precipitate any negative thoughts that had not already occurred to my participants prior to my research. Even so, I avoided asking direct questions on this issue, allowing my participants the choice of disclosing any such experiences. Further, I believed I had developed sufficient counselling experience to deal with any distress, although I had arranged for a qualified therapist to provide counselling if necessary.

To further safeguard my participants I aimed to establish rapport and conduct the interviews in a person-centred milieu. This aimed to approximate a person-centred attitude which assumes an equal status relationship, bearing in mind that the purpose of our relationship was research not counselling. Specifically, I would communicate empathetic understanding and unconditional positive regard (core conditions as advocated by Rogers, 1957)[11], and value the participants' ability to produce a collaborative and negotiated piece of research (Robson, 2011). Robson (2011) writes "personal involvement of the researcher is required in order to help them to take the position of the respondent and see human life as seen by people themselves" (p.23). Hall and Hall (1996) also highlight the active, non-exploitative, symbolic link between the researcher and the researched as equals in a genuine exchange.

[11] The remaining core condition assumes the client/participant is in a state of incongruence relative to the therapist. It would be inappropriate, even disrespectful to make such an assumption as the participant is not seeking therapy or personality change.

These ethical principles are consistent with the aims of emancipatory research (such as this research) and are relevant to my participants as a potentially marginalized group.

Informed consent forms a vital part of ethical research practice. In this case all support agencies involved in recruitment were provided with comprehensive and accurate information before they made phone contact with potential participants. They only passed on contact numbers for people who had expressed an (informed) interest. No interviews took place before participants had read the Participant Information Sheet, and read and signed the Informed Consent Form. Participants were informed they could withdraw at any point without incurring any adverse consequences (feelings of 'failure' or my disapproval). All Participants were debriefed at the end. They were also offered an opportunity to contact me (and/or my supervisor) should any problems or questions arise after the research had finished.

Protecting confidentiality is also vital, particularly for my participants who were likely to have experienced difficulty in acknowledging their partner's drink problem. Written assurance of confidentiality was provided and reinforced by my personal promise to provide anonymity.

Research involving even potential change, as in this research, poses additional ethical challenges (Robson, 2011). In this case of this research we need to be mindful not eroding the participant's security in familiar coping strategies and take care not to undermine their relationship with their partner.

Finally, a consideration of ethics does well to consider ways of benefiting both the participants and in this case the enterprise of counselling psychology. Robson (2011) believes that psychologists need to 'give away' their skills in the process of ethical research. This study gave time to a marginalized group of people and space for them to express their thoughts and emotions about a difficult aspect of their lives. Through providing this 'safe' and non-judgemental space it may also allow them to reflect and provide an opportunity for some 'normalising' of their difficult experiences. It may even facilitate some positive reappraisal which might enhance the participant's lives and those of their partner.

Chapter Three: Findings and Analytical Dialogues

3.0 Overview

The participants in this study were asked questions which sought to explore the experience of being a current partner of a problem drinker. Without exception all ten narratives revealed that living with a problem drinker was associated with significant challenges to the women's sense of wellbeing and their ability to remain in a relationship with their problem drinker, but they also attest to resilience and personal growth.

Of note these women had stayed with their partner through enormously difficult circumstances (Ruby still does) having had to withstand pressure to leave from all quarters, not least of all their own sense of morality. The analyses suggest that their decisions were not easy, rather they involved complex and dynamic ways of construing their experience. Judging by the introductory literature relating to alcohol-related marital problems, these women have 'beaten the odds' by staying with their problem drinker.

The women's narratives contain a strong sense of evolution of the drinker's path, which in most cases gradually led from 'normal life', through a period of increasing concern and perplexity, into the 'thick of it', eventually to 'rock bottom', and then remission and beyond for nine out of the ten drinkers. Only Ruby's husband Ray continued his heavy drinking.

Given the evocation of a 'journey' the themes derived from the women's narratives are placed in 'chronological' order under the title *"The drinker's path as partners' reality and challenge".* The journey represents the relatively common 'reality' in which much of the partners' meaning-making or themes are embedded.

All themes are suggestive of complex, multi-faceted, and dynamic processes in their 'messy and chaotic' complexity (Eatough and Smith, 2013). Further, all themes appear to contain a strong sense of the women experiencing and re-experiencing challenges both to their psychological wellbeing, sense of identity, and to their relationship with the problem drinker. Such dynamic appraisals are suggestive of a regulatory process in which the women attempt to balance conflicting and contradictory influences seemingly involved in remaining with a problem drinker. This self-regulatory aspect of the women's experience is explored more fully in the discussion section.

In sum, six superordinate themes, or ‘locations’, comprise the current journey (drinker’s path) and evolve alongside the dynamic process of interpreting and responding to a changing reality. These themes are: *Life before the drink problem; a creeping onset; in the thick of it; reaching rock bottom; resurfacing reservedly* and *navigating new relationships.* Each superordinate theme contains a number of clustered sub-themes. Some of these subthemes appear and subside, some reappear with distinct changes, and some seem to pervade the entire journey.

3.1 The Drinker’s Path as Partner’s Reality and Challenge: The Journey

All themes, their introductions and analyses, are derived from my interaction with the data in an attempt to explore and meaningfully interpret the participants’ experiences (Willig, 2013); thus embrace IPA’s double hermeneutic.

Table 3.1 provides a summary of the superordinate and subordinate themes along with illustrative extracts. A ‘story board’ diagram (Figure 3.1) provides an illustrative schematic representation of the ‘journey’ to allow the reader to travel with us.

The Drinker's Path as Partner's Adversity and Challenge

BEFORE the drink problem

Superordinate Theme One: '*Life Before the Drink Problem'*

Life was … "just normal I suppose" [Mary].

Subthemes:

[i] *'Halcyon Days' Life was never a problem then … It was just nice* [Christine].

[ii] *'Counting blessings' We had a life which was idyllic, pretty house, smart cars, we could afford holidays to places people weren't going to at that time ... we were having a good life* [Fay]

[iii] *'Considering causes' We had a very different culture on alcohol* [Denise] *Alcoholism is a progressive illness with no cure* [Ruby]

DURING the drink problem

Superordinate Theme Two: *'Creeping Onset'*

"The thing is you don't see it till you're up to your neck in it" [Christine]

Subthemes:

[i] *'Being the social conscience' He can't see he's disgraced himself* [Heather]

[ii] *'Becoming weighted down with worry' I'd worry about his bad [drunken] behaviour …and … and … and* [All]

Superordinate Theme Three: *'In the Thick of It'*

"In the midst of the problem it was horrendous" [Christine]

Subthemes:

[i] *'Losing Dr Jekyll and living with Mr Hyde'*: *This was a different man to the one I loved* [Christine].

[ii] *'Appealing to Dr Jekyll'*: *I'd try to make him realise I mean business, I'm not putting up with it any longer* [Christine]

[iii] *'Being Mother'*: *I carry the responsibility of his sobriety.* [Denise]

[iv] *'Self-preservation'*: *I just have to make sense of it in my own mind* [Beverley]

[v] *'Feeling isolated'*: *I felt completely isolated there was nobody, no phone calls, nothing.* [Beverley]

[vi] *'Regarding others as mixed-blessings'*: *To say something to someone who's never experienced it, the answer is well just leave isn't it, if you can't deal with something, if you don't like it …[but] things aren't that simple?* [Olivia]

Superordinate Theme Four: *'Reaching Rock Bottom'*

"It was reaching a critical point and it all changed anyway" [Olivia]

Subtheme:

[i] *'Experiencing relief and positive emotions'*: *Oh I am so grateful those days are over* [Christine] *I now have the freedom of being able to think things through* [Olivia]

AFTER 'rock bottom', he has stopped drinking

Superordinate Theme Five: *'Resurfacing Reservedly'*

Where am I now? [Researcher's 'double hermeneutic']

Subthemes:

[i] *'Considering sunk costs'*: *When you've invested a lot you are have basically two choices – keep investing in the hope it comes good, or cutting your losses* [Olivia]

[ii] *'Revisiting responsibility'*: *I knew it was never going to be the same if he came back and starting drinking again* [Olivia]

[iii] *'Gaining strength through adversity'*: *I'm a different person, hope I'm a better person, more caring person.* [Christine]

Superordinate Theme Six: *'Navigating New Relationships'*

I'm trying to understand life with 'dry' Dr Jekyll
[Researcher's 'double hermeneutic']

Subthemes:

[i] *'Positive future expectations'*: *You've got to be positive that they'll stay in-recovery.* [Christine]

[ii] *'One day at a time'*: *I take each day as it comes at the moment … we're not out of the woods yet*. [Gemma]

[iii] *'Living together apart'*: *He's found some reason for going on, and that reason isn't me* [Sandra]

[iv] *'Drink as the elephant in the room'*: *I won't drink because I don't want him to drink* [Gemma]

Table 3.1: The Drinker's Path as Partner's Adversity and Challenge: Summary of superordinate

Overview: As the women looked back to the pre-drink problem days the prevailing sense was happiness and contentment with their partners and their lives. References to drinking were embedded in 'normal' social or work contexts and were not viewed as problematic.

Subthemes: *Halcyon Days; counting blessings; considering causes*

"

Overview Gradually the women began to notice their partner getting drunk very quickly, becoming argumentative, secretive and behaving badly particularly in public. The women became increasing concerned and worried about the changes in the dynamics of their relationship.

Subthemes : *Being the social conscience; becoming weighed down with worry*

Overview It is now obvious that the men have developed a drink problem and the women are increasingly feeling that they are living with someone that they don't know and don't like. They are also increasingly becoming burdened with responsibility for "keeping everything going" and trying to cope with very difficult and upsetting circumstances.

Subthemes : *Losing Dr Jekyll and living with Mr Hyde; appealing to Dr Jekyll; being mother; self-preservation; feeling isolated; regarding others as a mixed-blessing* .

Overview This 'location' represented 'as bad as it got' for nine of the ten women. In most cases the problem drinker had reached a critical point and had sought or found themselves in rehab. The women were also at a low ebb and this dramatic change from drinking to excess to being 'dry' seems to have marked a turning point in their future stances.

Subtheme : *Experiencing relief and positive emotions*

Overview The essence of this theme is that of contemplation and reflection. The women seem able to take stock of their current situation and start to envisage the future in a different way.

Subthemes : *Considering sunk costs; re-visiting responsibility; gaining strength through adversity*

Overview This last superordinate theme shows the greatest separation of the women in terms of their approach to their 'new' sober partner, their co-joint future and their own well-being. There appear to be three potentially overlapping future 'paths' – broadly optimistic, realistic and pessimistic.

Subthemes : *Positive future expectations; one day at a time; living together apart; living with drink as the elephant in the room*

Figure 3.1 The drinker's path as partner's adversity and challenge

3.2 Superordinate Theme One
'Life Before the Drink Problem': *Positioning themselves*

The drinker's path begins with the participants' accounts of life before the development of a drink problem, when life was *"just normal I suppose"* [Mary].

At the start of most relationships *both* partners had been social drinkers. Most of the women seemed happy and satisfied with both their life and their partner. Our interviews revealed a clear sense of the women wanting or perhaps needing to position themselves within these 'normal' lives. This positioning includes within their relationship to the drinker, their family and friends, with me during their interviews, and crucially within their own understanding of themselves; Wood, Gosling and Potter (2007) note the importance of 'normality evaluations' for a sense of wellbeing. Consequently, the first two subthemes explore the women's *'Halcyon Days'* and *'counting blessings'*.

The third subtheme, *'considering causes'* reveals something of the women's views, beliefs and cultural influences that also 'scaffold' their decisions to remain with a problem drinker.

3.2.1 Halcyon Days

> *Life was never a problem then [when we first got married] you know. It was just nice* [Christine].

Christine's extract exemplifies the women's attempts to position themselves in happy beginnings. This involves both a personal positioning for their sense of wellbeing, dignity or congruence, and 'telling me' where they wish to be located within their 'reality' of their partner's drink problem.

The majority of women portrayed their partners as 'normal' men who *"like a drink like everybody else"* [Christine]. In fact all women described enjoying drinking *with* their partners in the pre-drink-problem days; including Olivia and Oscar who got drunk together as teenagers. Drink seemed to be a normal part of these women's lives; in the pub, with friends, for intimate dinner parties, birthday celebrations, at weddings, funerals, and special occasions.

Mary met Martin for example, at his brother's wedding at which he was the best man.

> *You know we just got on, I thought he was really cute and we just used to drink to be sociable I suppose. You're young, you're out, you're going to pubs, you're visiting friends and so you're totally unaware at that point.* [Mary]

Mary's *"cute"* has a similar child-like quality to Christine's *"nice"* (above) and her extract exudes a sense of youthful naivety and care-free existence. Mary seems keen to tell us that she did not see the drink problem 'coming' at this point. Held (2002; 2004) argues that people can be vulnerable to an 'I didn't see it coming culture' if they lack congruence to their environment through endorsing too naive or optimistic a view of their lives. Certainly I gained a strong sense of life viewed as 'rose-tinted' *'Halcyon days'* before the drink problem took hold.

Gemma and Greg met through their common interest in meditation. Gemma was looking for a companion as she had grown distant from her husband who did not appear to value or take an interest in her, and gave her no encouragement. Greg was different,

> *I talked about my problems and he talked about his* [Gemma]

It becomes increasingly apparent that most of the women, especially those who have had previous partners, value their pre-drink problem partner for his companionship and as someone to talk *with*. Mutual self-disclosure and confiding are believed to be key aspects of satisfying relationships (Davidson, Balswick and Halverson, 1983; Hulson and Russell, 1991). These aspects of closeness change most significantly as the drinkers' path proceeds into the *'thick of it'* and engenders significant distress.

Sandra's extract clearly reminds us that we looking at retrospective accounts.

> *He was very good, a tonic actually. We had a lot of interests in common, we got around socially and I introduced him to quite a few people, it was good at first* [Sandra].

This extract illustrates Sandra's happiness and pride at finding *"a tonic*" after her distressing past experiences which included marriage to an alcoholic who died from drink-related causes, followed by a *"disastrous affair with an unsuitable man"*. However, her *"it was good at first"* seemed to 'warn' me indirectly that it was not good now. Boniwell and Zimbardo (2003) distinguish between two past time perspectives, 'negative' (focusing on aversive or noxious experiences), and 'positive', as here, which focuses on pleasurable, nostalgic, relationship orientated experiences. Sandra, as we shall see later, seems the least happy in her current life with Simon as a 'dry' partner, so I argue that her wistful negative comparisons to the present may represent pessimism and discontentment rather than positive positioning.

The elusive concept of love is also introduced,

We were both desperately in love. It was not a flash in the pan [Fay]

Love is irrational … I'd just be near him and I'd melt [Ruby]

It is not possible to do full justice to the women's meanings and beliefs about love within the confines of this study. I argue however, that these such protestations of love served as genuine and powerful explanations for remaining with a prized partner who had developed a drink problem, rather than to 'cover up' an abusive relationship (e.g Strube, 1988). I found it particularly poignant in Ruby's case as she faces an increasingly difficult future whilst Ray continues to drink heavily;

I know that ultimately, if it continues like this, he will kill himself. [Ruby].

The women's prevailing purpose is seemingly to demonstrate that their partners had not always been difficult problem drinkers; this was particularly evident in the early sections of the interviews. The happy contexts above provide a platform for the remaining two subthemes which further convey the women's attempts to explain, justify, and position themselves as sane, sensible, loving partners of (otherwise) decent men.

3.2.2 Counting Blessings

Although this subtheme is closely related to the *'Halcyon days'* I considered it sufficiently distinct by reference to the women more actively construing experience to create a sense of well-being. Both Christine and Fay for example, provide what struck me as a list of 'well-rehearsed' blessings aimed at gathering the 'good' around them before they told me their terrible story.

We've both worked all our lives, got a good family on both sides, good network of friends, we've had holidays and travelling, enjoy similar things like music, concerts and gardening. On balance we've had more happy events than bad. [Christine].

We had a life which was idyllic, pretty house, smart cars, we could afford holidays to places people weren't going to at that time. We did a lot to improve the house and things were going on all right, we were having a good life, we had good luck. [Fay].

Emmons and McCullough (2003) recognise counting blessings as an important aspect of gratitude and being associated with greater happiness. Similarly Fredrickson (1998) believed that the experiencing positive emotions, such as happiness and contentment, highlighted above, might convey a sense of comfort and protection from harsh realities of what is to follow. Tugarde and Fredrickson (2004) developed these ideas into a 'broaden-

and- build' theory for enhancing resilience. Christine for example spent most of the early part of her interview talking about how she and Colin had enjoyed an almost perfect life.

Of note, Fay sets her blessings within the 'negative context' of a *"hard life"* with *"a high-powered job"* that involved a *"stressful commute to London"*. These caveats lend 'grounding' to her recollections which resonates with her self-confessed pessimistic tendencies seen elsewhere in her narrative.

Christine elaborates on her orientation to life by saying,

> *I try to look at my blessings and look at others and consider myself optimistic.* [Christine]

Christine seemingly reminds herself to be positive which resonates with arguments for 'intentional activity' to maximise happiness (e.g. Lyubomirsky, 2001; Lyubomirsky and Ross, 1997; Lyubomirsky, Sheldon, and Schkade's, 2005; Lyubomirsky, Sousa and Dickerhoof, 2006). They are also consistent with both Snyder et al.'s (2005) expositions of 'hope' and Olasan and Roger's (2001) conceptualisation of 'fighting spirit', as they facilitate enthusiasm, energy and drive. Such positive or 'approach' coping strategies also allow the individual construer to supress tendencies to become embroiled in potentially negative emotional processing (Suls and Fletcher, 1985). These positive 'energisers' are all consistent with optimistic orientations which appear favoured in times of adversity (e.g. Scheier and Carver, 1985; Carver, Pozo, Harris, Noriega, Scheier, and Robinson, 1993). For example, Christine's next extract highlights optimism-sustaining arguments based around her ability to generate worse-case-scenarios that had fortunately been avoided.

> *Thankfully he was never a bottle of vodka a day guy, he just drank strong beers, which isn't so hard, although it obviously had the same effect upon him ... if he had have drunk the other stuff it probably would have killed him by now* [Christine].

Fay also counts her blessings through positive comparison, but her belief that *"life's a bitch"* again seems to signal greater congruence to harsh realities.

> *I wouldn't wish it [drinking problems] on anybody, but I recognise that life's a bitch and we could have come out of it a lot worse than we did* [Fay].

Christine however makes her comparisons (below) with *"some people"*, making them sound less harsh and somewhat 'warmer' than Fay's?

> *Thankfully we haven't lost thousands of pounds or our home. Although horrendous, it wasn't as bad as some people; some have lost everything, families, jobs* [Christine].

It seems that the women err towards thinking – 'even though the drink problem days were bad they withstood because it could have been worse'. I also however, gained a wistful sense of 'good times past' and the feeling that 'real' people were missing from these rather idealised extracts.

In sum, the women seem to be reminding themselves, and telling me, what 'good' reasons they *had* to remain with their problem drinker.

3.2.3 Considering Causes

Velleman (1993) recognised peoples' apparent need to explain the onset of drink problems and attribute causality. In this study, considering blame and responsibility appears a common undercurrent in the women's meaning-making throughout their journey with a problem drinker. I identified a number of distinct interpretations of causality which appeared sensitive to 'location' and intent. For example, a part of the women's early positioning involved ways of distancing themselves and/or the drinker from responsibility. Consequently, the most prevalent interpretation was that the drink problem was caused by* factors and influences for which their partner was not solely to blame.

Stress and emotional pain for example,

> *I think David abused alcohol as a way of either, I don't know because I'm not inside his head, but as a way of blocking out the pain or dealing with something that was what I would term post-traumatic stress.* [Denise]

David's *"trauma"* was work problems
which Denise believed affected his self-esteem and his ability to look after himself. She says *"the drinking became a way of escaping from that"*. Denise also believes that she and David grew up around very different drinking cultures.

> *We had a very different culture on alcohol … I mean my mum was abstemious and my dad would go out and drink too much on a Friday night and that would be it.* [Denise]

Similarly Christine places Colin, but not herself, in a *"drinking family"* from which he was unable to *"know when [he'd] had enough"*. Elsewhere Christine identifies a number of *"alcoholics"* from Colin's family and also believes that his drink problem may have *"started a little bit"* following the shock of her near-fatal road accident when her father *"fed him large whiskeys"*. Christine's expression *"the beer had got his tongue"* also allows her to remove the problem from her husband's conscious control and place it as drinks' responsibility; she additionally blames tiredness. These interpretations are consistent with later themes which

relate to preserving *'Dr Jekyll'* in the midst of his 'battle' with *'Mr Hyde'* and *'being mother'*. They effectively support, 'shelter' or preserve the problem drinkers as people who are not responsible for their drink problem. This stance helps the women to separate themselves from their partner's drink problem, leave it in the past, and welcome a new 'dry' reality. Gelles (1987) however cautions us to the potential 'dangers' of allowing people to shirk their responsibility for abusive behaviour (particularly domestic violence) by attributing it to drugs, alcohol, or loss of control.

Ruby voices a rather different interpretation, although again it serves to absolve both her and Ray from blame.

> *Alcoholism is a progressive illness with no cure ... It's getting worse, his memory's going, he's self-absorbed and he's got this thing about focusing on his own projects.* [Ruby]

To believe that Ray is an incurable alcoholic places him firmly in a position of sickness and within the ethos and teachings of Al-Anon (1979). It places Ruby, as a staunch advocate of Al-Anon, within Cutland's (1998) therapeutic practice of facilitating PPDs to reduce their engagement with problem drinking. This interpretation also resonates with Reid (2009) who describes her female PPD's 'blaming' or allocating responsibility to anyone or anything as long as it "does not extend to her husband, her 'perfect love'" (p12); see Towns and Adams (2000) for discourses of 'perfect love'[12]. Ruby does indeed forgive Ray for much, even sustained infidelity in the name of "love". Forgiveness, viewed in such positive contexts, seemed implicit in many of the women's accounts. McNulty (2008) however alerts us to its potential damage to relationships and individual wellbeing if forgiveness is used continually for behaviour construed as destructive. Fay's lone but nonetheless important voice on causality and forgiveness, is a case in point.

> *I saw his weakness [alcoholism], unforgiveable weakness [as a] complete failure of the relationship.* [Fay]

To allocate *all* the responsibility for Frank's alcoholism to "*<u>his</u> weakness"* effectively absolves her from the responsibility for his drinking and emphasises the fact that he made his own choices. We shall see later that Fay's stance is consistent with both her distain for weakness generally and her admiration for strength and courage; both these preferences were interpreted as integral to her resilience and autonomy.

[12] Driscoll (2009) conducted an interview with Sheryl Gascoigne ('Gazza's wife) which resonated with the issues of 'love conquering all' and 'if I just try a little harder maybe…', i.e. accepting the responsibility for his drink problem and domestic abuse. See also Ussher (1998) who views violence as men externalising their unhappiness, anger and discontentment, hence their responsibility.

In sum, I believe that the women's interpretations and beliefs around responsibility are significant mediators of their recollections of the past, their expectations for the future, and their ability to enjoy their current relationships.

3.3 Superordinate Theme Two
'A Creeping Onset': experiencing pressure to change

All women, with Denise to a far lesser degree, described noticing their partner's drink problem develop during a process of *"creeping"* [Fay] realisation. They started noticing 'odd' and what they considered *"anti-social behaviour"* [Sandra] for reasons they seemed not to fathom. Heather's account of her early suspicions typifies the women's increasing concerns that 'all is not quite right'.

> *I'd find a cut glass tumbler on the shelf in the pantry and wonder, what's that doing there ... then … even the drink he didn't like, like Malibu, would go. It was getting apparent that anything that was, had a lid on it and was drinkable, he would drink … it was hard to pin point [the start]* [Heather]

The identification of a *'creeping onset'* is consistent with authors such as Velleman et al (1998a+b) who document the often imperceptible early path of a problem drinker. I also gained a strong sense of resistance to 'evidence' of a drink problem and an unwillingness or inability to believe that this was happening to them. Christine, like most women, reveals a sense of disbelief and incredulity.

> *It was never a problem you know, I didn't think it was really happening to <u>me</u>. … It was like most people do I suppose - a bottle of wine at home and with friends for a meal, or just a drink at weekends ... It's difficult to say when it started to become a problem* [Christine].

Christine seems to express a sense of injustice which is at odds with a common existential assumption of the world being a 'fair' place (Janoff-Bulman, 1992, 1999), and her life with Colin as Jehovah's witnesses. There is also an undercurrent of Christine and Colin having drifted apart from a position of joint enjoyment of *social* drinking. Similarly, Mary saw Martin's drinking problem as an extension of 'normal' social drinking within a work culture.

> *We just used to drink to be sociable I suppose [...] then his drinking increased but it was part of the territory [of his work in media]* [Mary]

The reference to *"we"* seems important as it suggests a joint endorsement of drinking in the *"social"* student culture in which they met. Mary also tells us that as Martin got older she began to notice that he was getting drunk quite quickly. This phenomenon features in other accounts, for example Sandra,

> *Very, very, gradually I started to realise that I thought he was mixing drinks … and then I was feeling that we'd go out and he'd have one drink, like a pint of beer or something, and then we'd order wine and suddenly he'd be drunk and I began to think there's something odd here.* [Sandra].

The recovering alcoholics in Gubi and Marsden-Hughes (2013: 205) describe so-called 'topping up', "a process of always being drunk but not appearing to be drunk". Topping up of course would often be invisible to the women so the addition of a bottle of wine with a meal would disturb this delicate balance. This might explain why Christine's extract (below) appears as *her* incongruence amidst increasing evidence of Colin's drink problem.

> *I just think he was tired and what he drank was peanuts*. [Christine]

Christine's use of the word *"peanuts"* sounds child-like and rather understated and may be an attempt to reduce the potential seriousness of Colin's drinking.

Again Fay's description of realisation is distinctive by her reference to Frank's drink problem as *"alcoholism"*, a word which often seems avoided.

> *My husband's alcoholism crept up on me, I think it was there a very, very long time before I either recognised it, or was prepared to recognise it. I don't think I was consciously shutting it out of my head, but I may have done.* [Fay]

Fay seems to appreciate that recognising the problem, not *"shutting it out",* is helpful, whilst indirectly acknowledging that she considered denial an understandable response. Her use of *"husband"* rather than Frank may be an attempt to depersonalise his drinking. However her use of (his) *"alcoholism crept up on me"* seems to signify a leaning towards her taking this problem personally, as we shall see later.

Mary highlights how the escalation in Martin's drinking seemed to change the quality of their relationship and family life.

> *The relationship was getting weird … One night he just laid down in the corridor and that's where he stayed all night, always when he was going out with friends – so that was alright as far as he was concerned, then when children came along it just started to intervene in family life.* [Mary]

Mary's extract tells us that her *'creeping onset'* was a relatively slow and sustained experience and that the arrival of children was a significant turning point in her interpretation of Martin's behaviour. Mary seems to accept Martin's belief that his drunkenness with friends *"was alright"* but then re-interprets this as more serious *"when the children came along"*; here she was expecting him to be more responsible. Hulson and Russell (1991) and Ruble, Fleming, Hackel, and Stangor (1988) view the presence of

children as significant agents of change in a relationship and add to the complexity of sharing responsibility in the midst of a drink problem.

The following extracts highlight the naivety, denial, inexperience, and a sense that the drinking problem 'arrives' from 'I didn't see it coming culture' (Held, 2004), respectively.

> *I was so naïve … it got steadily worse and worse* [Beverley]
>
> *You don't see it because you're in denial … an alcoholic is – oh they're all dirty old men in raincoats, so him an alcoholic – No!* [Christine]
>
> *I know I must be the world's most stupid fool that it never occurred to me that he was drinking … but life got more and more difficult and he just completely wasn't there for us as a family.* [Denise]
>
> *Simon was a totally different person [to my ex-husband who was an alcoholic], so you know I didn't think anything about it* [Sandra].

Eventually the women's realisation involved reducing the distortion or denial of reality, 'rejection' or re-assessing stereotypes of alcoholics, letting go of false assumptions, and recognising the possibility that *their* partner could have a drink problem. Christine for example extends her earlier *"dirty old men in raincoats"* and *"people who've had breakdowns"* stereotypes,

> *I've gone beyond that [stereotype] they're people who've had breakdowns, a lot of professional people, doctors and firemen and the music industry, most of them are very, very nice people".* [Christine]

Now Christine acknowledges that *"professional and very, very nice people [including Colin]*" become alcoholics, she can accept this for Colin.

I propose that the slow build-up of 'evidence', coupled with resistance to change well-established assumptions, left most of my participants unprepared for the rigors to come. As Christine says,

> *The thing is you don't see it till you're up to your neck in it* [Christine]

The two subthemes during the *'creeping onset'* are *'being the social conscience'* and *'becoming weighted down with worry'*.

3.3.1 Being the Social Conscience

Embarrassment evolved as the strongest emotion in the early days of noticing the problem. The crux of embarrassment for these women seemed to result from a failure to prevent

others from perceiving 'the drink problem'. Christine for example, seems very uncomfortable going out with Colin as,

> *He tended to come out and slur slightly, [and] I didn't want people to think he was drunk* [Christine]

Embarrassment at meals at home with friends or at restaurants features highly in most accounts. This might be termed 'partner embarrassment' as there is a sense of trying to preserve a 'social mask' for their relationship.

> *Perhaps on one or two occasions, evenings [with friends], he'd even fallen asleep … that was embarrassing".* [Christine]

> *I got to the point where I couldn't sit in this restaurant any longer It's getting embarrassing, what was supposed to be a nice meal was getting spoilt by his escalating drunken behaviour.* [Heather]

> *I realised he was having far too much to drink and he was behaving oddly, and … was causing me distress, distress in public right [and] we'd have people in and he'd fall asleep … very antisocial behaviour* [Sandra]

Even worse at Sandra's Birthday meal in a local restaurant,

> *Gradually [I realised] he was addled and not making sense … then suddenly he was absolutely blotto you know and so he was well, talk about men behaving badly … oh my God I mean I know people saw him. It was my birthday and I thought well why do this to me … and I began to think what's the matter with this man … I suddenly thought I don't want to be with this man, I don't want to be seen with him"* [Sandra]

Again the main issue seems to be "*know[ing] people saw him*". Sandra's embarrassment is strong enough to 'ask' *"what's the matter"* with him and whether she wants to be *"seen with him".* On this occasion she left the restaurant, walked home and locked Simon out for a couple of hours. She ended this story by saying, *"you see I was unhinged as well obviously";* I noted with sadness and compassion that Sandra considered herself *"unhinged"*.

Olivia also reveals bleak and psychologically solitary evenings out, seemingly infused with embarrassment, but without direct reference to others; this feels more internal and private.

> *Evenings out were a disaster. If we went out for meals he would never eat anything. The meal would just be sitting on his plate and it would just end in trying to get home as quickly as possible really … out of embarrassment of being out with someone who's drunk* [Olivia]

Almost as an aside Olivia added, *"He was always enjoying <u>himself</u>"* which served to emphasise the absence of *shared* pleasures.

I got the strong sense that whilst Oscar was drinking, all their life together, bar the time after recovery, Olivia was just 'going' through the motions – like he was living, doing what he wanted, enjoying experiences, she was almost like a shadow, an observer.

Heather's accounts of embarrassment introduce unpredictability as a significant feature of her experiences. Heather described how Henry was *"so nice"*, at her brother's wedding, that she decided to *"risk"* joining him at a business dinner with a group of potential Australian clients. Henry however became very drunk and *"disgraced himself"* in her opinion. She offers the following explanation,

> *Because the Australians were there he thought he had to live up to this person that he thought he should be in their eyes, and he just used to make a complete prat of himself. He can't see he's disgraced himself* [Heather]

The evening above ended badly with Heather being scared to be alone with Henry when they returned home. This highlighted another common thread in that problem drinkers are capable of creating really embarrassing public scenes followed by abuse and violence at home. Also note however, that Heather places the responsibility for this unpleasant evening squarely on *his* shoulders.

Heather also reveals what amounts to being ashamed (with a very sad resignation in her voice) for her children on Christmas Day when Henry fails to surface at a reasonable time to open presents.

> *If you can't make an effort for children on Christmas Day then go away* [Heather]

Delargy (2011) discusses the effects of alcohol problems on parenting and refers to problem drinkers become less loving, caring, nurturing, consistent and predictable, with less supervision of their children and inconsistent discipline (Velleman and Templeton, 2003).

Staying with children, Fay describes how her daughter first noticed Frank's drink problem and her primary emotional response was also embarrassment.

> *She would say he just sleeps and then she'd be embarrassed because he'd sneak round to the village shop buying cans of special brew which I didn't know anything about, I just wasn't there and she'd be embarrassed because her friend's father ran the local shop, she felt embarrassed by his behaviour* [Fay]

Also,

> *He fell over, unaccountably getting out of the car [driving his children], he's not a clumsy person. I'm the clumsy one."* [Fay]

In sum, the theme *'being the social conscience'* attests to the power of social norms and 'rules of etiquette' to influence the women's phenomenological experience and their behaviour. It seems the non-drinker becomes acutely aware of the eyes of others and they feel a need to do something to avoid or 'rescue' the situation; almost acting as a social regulator. Heather for example errs towards avoidance or 'not airing dirty washing in public'. Others such as Christine, Olivia, and Sandra attempt to reduce the likelihood of embarrassment by 'gently' steering their partners away from having another drink. These interpretations resonates with Barker's (2013) caution regarding trying to 'fix' other peoples' problems, and Meichenbaum's (1975) advice to therapists not to be their client's frontal lobes. In contrast the problem drinker seems to increasingly retreat into an egocentric world (Shinebourne and Smith, 2009).

3.3.2 Becoming Weighed Down with Worry

Worry seemed to warrant its own subtheme, but even this signalled a range of emotional experience from vague feelings of foreboding, to more explicit worry, to extracts which resembled negative automatic thoughts (NATs). This theme is also visible throughout the entire drinker's path although its quality and meaning seems to change as the drink problem evolves.

Worry then is a significant feature of the women's experience as they gradually realise that their partner's drinking is becoming a problem, although much of this seems to be experienced alongside the embarrassment we saw above. Christine recalls this clearly.

> *I'd worry about his bad [drunken] behaviour, what he'll do or say with friends, the shame, the embarrassment. I didn't know what to expect, like when I came home from work, was he there or not, if so, was he ill* [drunk]? [Christine]

Christine's rich but unhappy extract reveals a multitude of worries, combined with shame and embarrassment and which seem to stem from deep uncertainty and insecurity, both personal and practical.

Worry increases as the women become enmeshed in the very difficult situations in the *'thick of it'*.

It is not possible to provide an exhaustive list of these women's worries so the following represent some of the most common.

> *I'd worry about… his safety* [Christine, Olivia]

… his mental health [Olivia, Denise, Ruby, Fay]

… how he'd behave with friends [Christine, Ruby, Gemma]

… whether I could leave him alone. [Christine, Olivia, Beverley]

… when he didn't answer the phone [Beverley, Gemma, Olivia]

… about keeping everything going [Christine, Olivia, Ruby]

… how long his boss would tolerate his problems [Gemma, Sandra]

… when he'd shout at me again. [Gemma, Heather, Mary, Fay]

Christine also says,

His drinking would be <u>constantly</u> on my mind … it was hell. [Christine]

This brief but important extract suggests that the drinking problem takes over the partner's life through constant worry and rumination. Of note Christine appears to have experienced significant relief when Colin stops drinking, although worries of a different kind resurface for her and others as their partners maintain their recovery; these issues will be explored below.

Sandra initially explained Simon's drink problem as a consequence of his having problems dealing with demands and difficulties stemming from his ex-wife. However, she later voices her worries about being used.

I began to think, this is, I've been brought along this road under false pretences, almost, maybe, I was being used? [Sandra]

This thread was very cautiously conveyed and was not a prevalent theme, which prompted me to consider it indicative of the pervasive sense of insecurity, low self-esteem and lack of autonomy apparent in Sandra's narrative. She also feels very excluded and under-valued,

I'm being taken for a ride here because he's not telling me everything. [Sandra]

These extracts stands in stark contrast to Simon being *"a tonic"* at the start of their relationship and paradoxically reveals that she values sharing thoughts and opinions with a soul-mate. Sandra seems to construe her experiences in a way that locates her in a lonely place.

We shall see that *'worry'* appears side-lined in the women's experiences of their partners' in-remission, although it is not entirely absent. The following extract, for example, reminded me of the flashbacks and NATs (e.g. Salkovskis. 2007, 2008; Slakovskis, Thorpe, Whal,

Wroe and Forrester, 2003) that often characterise the conversations of survivors of trauma. Christine demonstrates her struggle to maintain a positive balance for her thoughts.

> *Sometimes I have the odd thought ... Colin'll go up the garden and sometimes just reminds you, an immediate thought is - what's he going up for? I can't help that, doesn't happen always, about 80% of the time I'm okay, because that's what used to happen you see. He'd go up the garden to the shed and have a drink. It still lingers with me, not violently so or anything like that* [Christine]

I believe such NATs are more frequent and cause more distress than Christine was able to acknowledge judging by her attempts at justification and dismissal. The following extract succinctly expresses her current worry.

> *I sometimes think what if he goes back?* [Christine]

She immediately countered this worry with a pessimism-banishing imperative.

> *"… but you <u>can't</u> live on the what ifs"* [Christine].

It seems that Christine tries to keep anxiety 'at bay', by drawing upon a consciously controlled tendency to deny herself pessimistic rumination and convince herself that everything is alright now.

Olivia also tells us how the worry still stays with her, and she has 'flashbacks', like Christine, *"when he doesn't answer the phone"*.

Sandra broadens the scope of her in-remission worry by considering AA's guidance.

> *They (AA) say that you are never cured you are always a recovering alcoholic.* [Sandra]

Sandra shows appreciation of the indefinite duration of the process of recovery, but may not fully recognise the complexity of definition of recovery (e.g. White, 2007), which involves more than giving up the drink (Irving, 2011). Recovering requires voluntary sustained control (Hibbert and Best, 2011), growth and self-change (Laudet, 2007) and congruence to 'forbidden' aspects of identity (Shinebourne and Smith, 2009). We return to these issues in the 'dry' stages of our journey.

In sum, it seems that *'worry'* accompanies the women along their entire journey. This however can be interpreted as a 'survival' strategy or simply a 'normal' part of life by way of maintaining congruence to 'reality' (Peeters et al. 1997; Waller, 2003); such functional qualities of anxiety will be explored more fully in the discussion.

3.4 Superordinate Theme Three
'In the Thick of It': Managing adversity

Regardless of differences in onset all the women described reaching a point where it became clear they were living with someone with a noticeable drink problem.

> *In the midst of the problem it was horrendous.* [Christine]

> *It was frightening, absolutely terrifying.* [Gemma]

They found little opportunity to think, reflect, or plan, rather they just acted and responded, often seeming overwhelmed.

> *It was absolutely totally awful, just awful.* [Fay]

This superordinate theme showed a high level of consistency of predominantly adverse experience and all participants revealed a plethora of negative emotions which appear interwoven through their narratives. Emotions such as anxiety, fear, disgust, embarrassment and loneliness all appear. The main source of concern seemed to be the realisation that their partner was becoming someone whom they did not recognise; hence the first subtheme, *'losing Dr Jekyll and living with Mr Hyde'*.

In the *'thick of it'* the women were increasingly under pressure to maintain a 'workable' life, and the worse it got the more they seemed motivated to manage, cope, or overcome their terrible situation. This is consistent with the theory and research outlined in the stress and coping perspective (1.5.2). Many of the women's efforts seem directed towards exerting influence on their partner, or managing and self-regulating themselves, often in a 'mixed', sometimes desperate fashion.

> *You just resort to shouting at each other don't you?* [Gemma]

Accordingly, three coping subthemes were identified: *'Appealing to Dr* Jekyll*; 'Being Mother'* and *'Self-Preservation'.* The prevailing coping tendency seems to be that of well-intentioned approach, although most women seem to know how much they can or are prepared to tolerate, and draw back to look after themselves.

Heather's extract below conveys a vivid sense of avoidance, psychological distance, and oblique references to the domestic violence that was becoming increasingly common for her.

> *He would be like an atmospheric hoover, you know when you walk into a room and it's full of noise and somebody walks in and it all goes quiet, well he's the sort of person who could make that happen. It was horrible, it was a horrible life, it wasn't*

> *pleasant, I never used to want to come home, would sit in the car outside the house. The car became my sanctuary it really, really did … but had to go in for the kids.* [Heather]

Heather's extract conveys a sense of loneliness and isolation as she tries to navigate the worst excesses of Henry's drink problem, which resonate with the remaining two subthemes, *'regarding others as a mixed blessing'* and *'feeling Isolated'*. It also highlights the importance she places on her role as mother, which often either 'ties' women into staying (e.g. Strube, 1988) or precipitates their leaving (e.g. Ruble et al., 1988; Street, 1991).

Mary also highlights what appears as Martin's distorted thinking and 'unreasonable' behaviour.

> *He thought it was perfectly acceptable to turn the table over [because he'd lost his temper]*. [Mary]

Referring to this type of domestic violence, she says, *"you begin to normalise that [but] I Gthink the realisation [of the problem] for him was very sad"*. Mary, like other women, occasionally provides glimpses of their interpretations of their partners' phenomenology. Here we are reminded that her problem drinker is also an unhappy individual at this point in their lives.

Christine's extract conveys the sense of her 'not mattering', which spoke for others, and signalled a very sad and lonely phase of their relationship with a problem drinker.

> *Nothing mattered but the drink, it got its grips into him, as it does, it got into his body if you like, his mind.* [Christine]

3.4.1 Losing Dr Jekyll and Living with Mr Hyde

A significant source of the women's discontent and discomfort stemmed from their realisation that they no longer recognised the man they described from their *'Halcyon days'*.

> *This was a different man to the one I loved and knew was a hard-working, caring man; he was like a Jekyll and Hyde.* [Christine].

Christine's reference to *"Jekyll and Hyde"* struck me as a perfect descriptor for the women's sense of distress and confusion at losing their 'good' partner, *'Dr Jekyll'*, and finding themselves with a 'bad' person, *'Mr Hyde'*. Interestingly, Willig (2012) discusses the enormous amount of interpretative activity that this well-known story has generated. She

notes that the most common moral allegory interpretation, which concerns the struggle between what is good and base in human beings, appears consistent with Christine's meaning-making. Further, this terrible experience seems infused with deep loss and sense of isolation.

> *Sometimes I'd go looking for him and find him passed out in the park [...] or he'd be in bed. He wouldn't eat, wash, get dressed; I wouldn't know what to do with him. I had to hide my money because he'd nick it to get a drink. I used to take my handbag with me to the shower, sleep with it beside my bed; I didn't trust him* [Christine][13].

Christine speaks of the worry, unpredictability, and implicit thoughtlessness that seem associated with their experience at this relatively heavy phase of their partners' drinking. Christine also conveys a sense of desperation, and I empathised with her shame and distress as she revealed that he used to steal from her. *I sensed that this was not an easy admission to make and felt humbled that she felt able to be so frank with me.*

Fay describes her *'Mr Hyde'* with disgust and revulsion in her voice.

> *Alcoholics do often look as if they've got a bad cold or flu or something, so I'd have this kind of sniffing, oh ... just horrible to remember it … this kind of lump of uselessness around the house, who would steal from me and lie to me.* [Fay]

Fay boldly refers to alcoholism and to Frank in a very distant fashion, but like Christine she reveals something of the burden, distress and isolation of living with a problem drinker. Fay then provided one of the starkest and most vivid extracts in the research to communicate her sense of horror at the man Frank had become.

> *One of the worst moments was, he did pick me up, often he'd forget, he came out of the station car park, round the roundabout and in front of us, a family of hedgehogs were going across the road … and he ran straight over them* [shock and revulsion in her voice]*. It was horrendous, he would <u>never</u> do that, he's a kind man.* [Fay]

Judging by Fay's body language and the emotion in her voice she seemed to experience this distressing event like a 'flashbulb memory' described by Matlin and Stang (1978). Interestingly this extract reveals a rare reference to both a 'softer' more sensitive side of Fay, and her affection for Frank as *"a kind man";* paradoxically this terrible event seemed to remind her why she had stayed.

Other women provided similar indications that they were living with a 'stranger':

> *He would get what I would call belligerent and he's not belligerent.* [Denise]

[13] However, at no point did Christine reveal blame towards Colin or any loss of affection; even *"I didn't trust him"* sounded matter of fact.

> *Because he was so full of alcohol he didn't know what he was doing. He wasn't the person that I knew that had done that to me (given me a black-eye).* [Gemma]

Gemma's extract again raises the issue of domestic violence, although this only appeared in a minority of other interviews, most notably Gemma's, Mary's and Heather's. Heather's experience of domestic violence appeared the most extreme and she even described believing that Henry wanted to kill her.

> *His temper was quite vile when it went … there were a couple of occasions where I thought I wasn't going to be breathing in the next few minutes and I'm serious about that. … I remember one specific occasion [when he was strangling me] and I just thought I've had enough of fighting him back and I'm going to just let him kill me because it seemed like that's what he wanted to do.* [Heather]

It got to the point where Henry's violent, often irresponsible, and seemingly uncaring attitude led Heather to conclude the man she had fallen in love with had gone.

> *I lost the person inside, the nice person, because it's a lot of this 'Big I Am', and that really wasn't the person inside.* [Heather]

Heather's extract above was chosen as a clear example of the loss of a soul mate that seems to typify the women's experience. Olivia suggests a slightly different, but equally insightful interpretation of *'Dr Jekyll's* disappearance'.

> *Oscar could be really annoying and difficult, though I knew underneath there was a really decent person. I knew in the early days because I saw it, when he wasn't drunk all the time … it was progressive, then towards the end I never saw that person much at all, but I knew he was there somewhere, things like he's good with people - that never changed.* [Olivia]

Olivia believed that her *'Dr Jekyll'* still existed even beneath the worst excesses of Oscar's drink problem, which acts as a strong 'protective' factor for her ability to remain with Oscar. This belief, and the occasional glimpses of the *"decent"* person she had fallen in love with, resemble the 'magic moments' referred to by Cutland (1998), and emerge as a powerful reasons for waiting for Oscar to stop drinking. Heather (above) also remembered the 'nice' person and this seemed to give her occasional strength and hope; this reminds me of powerful motivational effects of Behaviourist 'intermittent schedules of reinforcement'.

Some of the women highlight ways in which conversations appear to change, which make connection and companionship almost impossible. For example, Beverley talks about arguments and frustrations with Ben.

> *He was quite aggressive, quite argumentative if things weren't exactly his way, he'd make so many demands on me. We'd end up rowing about stupid trivial things. I just thought I don't know how to stop this really. I realised that I couldn't do anything really*

> *to help him it was very frustrating and I just feel useless really because you can't change something that's not good. I didn't like him when he was drunk, why did he drink, he didn't need to drink.* [Beverley]

Beverley appears hurt, confused and almost takes Ben's behaviour as a personal insult?

Gemma talks about Greg's *"deliberate provocation"* which she interprets as his attempt at control, made *"worse"* by drink. She also describes how Greg wanted to talk about his problems at bedtime when she needed to get to sleep.

> *He would start to talk absolute rubbish just to have an argument. I think he was trying to control me in a way* [Gemma]

Although most of the extracts so far indicate the loss of a soul-mate, deep disappointment and sadness, they also serve to highlight positive qualities that seem highly valued. Consequently I incorporated expressions of praise and love for the drinker as their lost *'Dr Jekyll'*.

> *He's a really lovely, caring, beautiful bloke* [Denise].
>
> *Ray was absolutely wonderful during all that time (when I had breast cancer), just looking after me. Nothing was too much trouble* [Ruby].
>
> *One of the things that did work, did help us, actually we had a run of dreadful bereavements … we really pulled together he was <u>really</u> supportive* [Mary].

Interestingly the majority of positive descriptions derive either from the time before the drinking problem took hold, or from non-drinking aspects of the couples' lives. The extracts above relate to David's qualities as a father, Ray's care and companionship when Ruby was in-treatment for breast cancer, and Martin's support at a traumatic time for *both* of them. Notably these examples of *"pulling together",* engaging two conflicting parties in *mutually* beneficial endeavour, is consistent with the ethos underlying interventions designed to help PPDs help their problem drinkers (e.g. Barber and Crisp 1995; Fals-Stewart et al., 2006; Miller et al., 1999). Tellingly Mary adds, *"it took that level of awful stuff going on"* for us to be together; this link reminds me of the early work of Sherif (e.g. Sherif, Harvey, White, Hood and Sherif, 1954/1961) who devised superordinate goals to 'make' conflicting groups of young boys cooperate and hence reduce conflict and prejudice.

3.4.2 Appealing to Dr Jekyll

Given the perceived loss or increasing 'invisibility' (Olivia) of their loved one a noticeable subtheme consisted of the women's efforts to manage or cope with adversity by appealing

to the person they knew and loved. These efforts saw most women engaged in interactions that seemed motivated by a desire to connect with their pre-drinking problem partner. Heather, for example, wanted Henry to be 'real' and genuine.

> *I think everyone should know who they are. I used to say to him, look you're in the home now, take the bloody hat off, I'm not a worker, I'm not 'Dave' at the factory … it's me.* [Heather]

Some women attempted to 'drag' their partners back into the present along with their previous 'normal', caring, supportive, responsible, responsive behaviour.

> *I'd try to make him realise I mean business, I'm not putting up with it any longer* [Christine – trying to assert herself]

> *I tried to tell him it's not normal for me to sleep on the sofa with the baby just because he can't handle his drink.* [Mary]

Fay attempted to make Frank see reason.

> *I would start to talk and try and get some rationality into things, but it would always degenerate into a fearsome row.* [Fay].

Whilst many women continue to try Fay pointed out what she saw as the futility of trying to talk to *'Dr Jekyll'* when he is behaving like *'Mr Hyde'*.

> *It was impossible to get through to him when he was drunk* [Fay]

Ruby also seems to have developed a quiet acceptance (rather than resignation?) of Ray's inability to be her soul-mate when he's drunk; this seemed to help ease the pain of her loss.

> *I've come to understand it's not him it's the alcohol which takes him away from me.* [Ruby]

The women effectively take a 'sober stance' and direct their energies towards facilitating insight of the drink problem in their partner as a first step towards recovery. This interpretation resonates with Miller and Rollnick's (2002) formulations for problem drinkers assessed as 'pre-contemplators' (unable to contemplate change and consequently are unlikely to benefit from therapeutic intervention) during a 'motivational interviewing' process.

Trying to contact *'Dr Jekyll'* appears so frustrating that some women resort to quite desperate means to vent their anger and perhaps 'wake him up' and stop him drinking?

> *I broke up the whole kitchen once … out of frustration* [Fay]

Fay had already described her attempts at *"talking to him"* and *"reasoning with him"* which *"got nowhere"*; her willingness to express anger can be argued as valuable in the context of trying to re-stabilise their relationship (see, Graham, Huang, Clark and Helgeson, 2008). Similarly, Heather describes doing "*things that would shock him, like I would through a plate at the wall"* to divert him from violent intent.

The women seem motivated to facilitate a return of their pre-drinking problem partner, or at least a 'dry' partner. Such tenacity of effort towards these goals seems consistent with Carver and Scheier's (2002) conceptualisation of optimists on an optimistic path. Carver and Scheier's (2002) catastrophe theory views optimists as inclined to sustain their goal-directed efforts, even in the face of significant (pessimistic) evidence to the contrary.

3.4.3 Being Mother

> *When he was drinking I used to liken him to a 5-year old, and after therapy I likened him to a 12-year old; so he's growing up, but he still acts like a child* [Beverley]

By the time the drink problem was well established the women had taken over the responsibility for an enormous range of practical tasks and activities that would normally be shared with a partner; like wage earning, running the home, household chores, planning social events, and child-care; consistent with data from Delargy (2011). The women had gradually become the financial, social and personal organisers for the partnership, effectively *'being mother'* to their problem drinker. In other words they were no longer equal status adults.

> *I was having to keep everything going - going to work, paying the mortgage … everything; he was on Incapacity Benefit.* [Christine]

> *I'd just put the children to bed on my own when he was in one of his moods, it's just easier.* [Mary]

Much of this additional burden for domestic chores and child care may be fuelled by cultural norms related to gender divisions of labour as discussed by Barker (2013) in 'normal' relationship contexts, and Holmila (1988; 1994) specifically regarding women assumed role in controlling men's drinking. Christine's extract (above) however highlights a common thread of 'extra' responsibility that seems to run counter to such cultural patterns in that she became the sole breadwinner and kept *"everything going"*. Similarly Beverley, Denise, Fay, Gemma, Olivia and Sandra also find themselves struggling to make ends meet on (their) one salary. Even Heather, Mary and Ruby whose partners manage to stay in employment take virtually, total responsibility in all other roles; like Mary above with the children. It

seems that the drinker is 'allowed' to relinquish responsibility by virtue of being irresponsible, like an adult child.

Denise's response to David's assumed irresponsibility was to allow him little self-determination, resembling a mother-adolescent stance.

> *I'd ask him where he'd been … I told all the local shop keepers not to sell him alcohol … I'd tell him he'd had enough to drink … I test him with a breathalyser when I'm suspicious, because I love him* **...** *I can't trust him with alcohol. I carry the responsibility of his sobriety.* [Denise]

Denise also arranged for David to see the same counsellor as her as she felt he was not able to choose or respond appropriately himself.

> *He played games with it [previous counselling] … not being honest … he was still in denial [at that point] about his alcohol problems.* [Denise]

Denise's interrogations, decisions, and arrangements are not really hers to make. She is effectively telling me 'where *he* was' at times, like *"still in denial"*. With regards 'his' counsellor, Denise reveals *'being mother'* as she *"made a fuss"* when she thought he had been *"waiting too long"* and *she* wanted him seen. Denise appears at the 'extreme end' of the theme *'being mother'* as her reported interactions with David appear very assertive (almost aggressive), proactive, and demanding; *"I need to know when he's going to be seen [by the counsellor]"*. This stance signals great investment for Denise and little scope for independence for David.

Some aspects of *'being mother'* seem less confrontational and more sheltering; wanting to keep their 'child' safe and care-free.

> *I kept saying to Colin, be careful how much you drink [or] you're going out you don't need a whiskey* [Christine].
>
> *People are sometimes unkind and say hurtful things … I don't always tell him of those.* [Christine]
>
> *I had to be cruel to be kind, I took him to AA meetings … I came back for him once and found he'd bunked off to the pub!* [Christine: mild amusement in her voice]

Christine's extracts portray a kind, considerate mother-figure, who tried to gently dissuade Colin from drinking too much, and shields him from unkind comments. Christine's 'kindnesses' however place her in a burdensome position. She is effectively reducing her potential to enjoy social events and to have unencumbered, equal status conversations with Colin. I wondered whether this was a form of self-sacrifice as only *he* would eventually

'loose himself in drink'. Similarly, Christine assumed the 'burden' of taking Colin to AA meetings (being 'cruel to be kind') because, like a child, he cannot be trusted as he *"bunks off to the pub"*.

Olivia also highlights what appears as Oscar's immaturity of thought and child-like egocentrism.

> *Judgement doesn't exist [when you're drunk], you [the problem drinker] always do something because you think it's a good idea at the time … whereas if you do something sober then that's a different matter because you're able to think about the consequences.* [Olivia]

Mary's observation almost seems to follow Olivia's by recognising that the *problem drinker* has to develop (cognitively).

> *The penny began to drop [that he couldn't work and drink so heavily] … and he stopped drinking.* [Mary]

This last extract contains a sense of 'mother' waiting for her 'difficult' adolescent to learn life's 'rules'. In Mary's case she hopes Martin will realise that he cannot keep drinking to excess, staying away all night, and *"crashing"* with his work-mates. He needs to be fit for the responsibilities of work and his family. I tentatively suggest, from a cumulative interpretation of Mary's dialogues, that Martin took his responsibilities to work more seriously than those to Mary and the children, because she compensated in this respect. This is also consistent with the findings of Sobell et al. (1993) that the majority of problem drinkers stop drinking unaided, which Reid (2009) draws upon as reason for PPDs to 'return' the responsibility for the drinker's choices, to the drinker.

Sandra, Olivia and Beverley also highlight rather passive but still burdensome aspects of 'mothering':

> *Sometimes I keep quiet to keep the peace.* [Sandra]
>
> *I'd agree to have a drink with him sometimes, not because I want one, but so he won't drink the whole bottle himself.* [Olivia]
>
> *I'd try and pacify him and reassure him (about my work weekends away)* [Beverley]

Sandra takes a common parental position of silent 'suffering', whilst Olivia's 'yes' (when she means no) to wanting a drink strikes me as the sort of 'white lie' that often shelter children from difficult or upsetting truths. Olivia frequently seemed to do things she would rather not do, effectively putting her own needs second; another common and traditional aspect of

'being mother' which is salient for these women, and myself. Olivia's extract below tells how she would curtail her own life by staying at home, *"that made things easier"*.

> *If I ever went out I knew Oscar would go out and could just disappear, so I was always better off being here because that made things easier. I couldn't leave him to his own devises, he wouldn't just stay put*. [Olivia]

In a vivid example Olivia describes Oscar *"disappearing"* for three days then phoning from France asking for a lift home; reminiscent of adolescent behaviour. This incident highlights a common interpretation of the problem drinkers as irresponsible and not to be trusted in many senses of the word.

Olivia's experience resonates with me as the mother of adult children – you have to let go, but it's hard because you think the safest strategy is to be with them, to know where, and how they are; even mobile phones are a mixed-blessing, when they're not answered. To feel that a 'child' is in danger is very uncomfortable and anxiety provoking. I also wonder how important it is that neither Olivia, nor Christine, have children. I tentatively suggest that they err towards gentle, forgiving, self-sacrificing 'mothering' as opposed to women who are mothers, who wish their partners to 'stand on their own two feet', particularly Fay through her intolerance to Frank's drink problem, and Gemma who explicitly resits 'being mother',

> *I don't want to use all my annual leave up babysitting [whilst he was in home rehab], I'm not being horrible, I'm not his mother, I shouldn't have to babysit him* [Gemma]

This extract masks Greg's request for Gemma to help him and stay with which raises the question of whether the men 'provoke' some women into assuming a mother role. Bennum (1991) notes the necessity of another person to validate adopted roles from a systemic perspective. In this case 'mother needs a child', but I am uncertain as to which role was adopted first. If it was the neediness of the men then might they have more in common with each other (certainly in this theme) than the women do?

During these reflections I was reminded of the studies designed to explore the personal or relationship qualities that were 'best suited' to helping their partner overcome their drink problem – supportive or confrontational, forgiving or 'cruel to be kind? These issues will be discussed in Chapter Four.

Finally the extracts above relate to the drinking stages on the journey, although many women continue to cherish, closet, protect and monitor (notably Denise) their partner in-remission; in other words they continue to *'be mother'*.

3.4.4 Self-Preservation

The subtheme *'self-preservation'* stands in contrast to the previous theme, *'being mother'* in that the main focus is *self*-protection rather than protecting the drinker. Even though the participants remain with their problem drinker their interviews revealed many and various attempts to preserve their own health and well-being. This current theme acknowledges the participant's agency in the process of attempting to balance her own needs with those of her partner and their partnership.

Many strategies for self-preservation seemed to relate to the *'thick of it'*. For some this involved private sense-making or reflection, suggesting that understanding the problem might afford some comfort.

> *I thought is everyone else doing this? I thought what can I do when things got bad … I wondered if it was me* [Sandra]

> *I just have to make sense of it in my own mind* [Beverley]

Some resort to denial, optimistic illusion or disbelief.

> *You carry on thinking it won't happen again, that it'll go away* [Olivia]

> *All the time when Oscar was drinking, if I wasn't with him I'd be quite good at thinking things weren't as bad as they were or wouldn't be that bad again … but it always was.* [Olivia]

Some, most notably Ruby accepts …

> *I accepted I couldn't change <u>him</u>* [Ruby]

Whereas Mary and Olivia's extracts may be more akin to resignation.

> *I just went along with it* [Mary]

> *I learnt to live with it [constant drinking] in the end. I decided there's no point in knowing the ins and outs* [Olivia]

Mary's modest expectations of life and liberal attitudes to Martin's rights to self-determination are reflected in her tolerant attitude above. She seemed satisfied *"as long as he didn't come home drunk"* and upset the children. Mary also accepted Martin's graded attempts to stop drinking, rather than insist on immediate total abstinence. Olivia's extract reveals a consistent aim to control and filter her thoughts and 'convince' herself that, *"things wouldn't be as bad as she <u>knew</u> they would"*. Her extract below suggests that she has 'evolved' tried-and-tested personal strategies for providing herself some respite.

> *I knew he'd eventually go to bed so sometimes, if I'd just had enough, I would goad him into stomping off and going to bed, and I'd be quite pleased about that, I'd have some peace [Olivia]*

Following from *'being mother',* this is like putting a child to bed to get some adult time, albeit as a single parent in this case. Olivia realised that this was quite a desperate way of getting some peace, rather than being able to discuss or negotiate, but she says *"after a certain point you can't talk to a drunk, it's just not possible"*.

Olivia also compartmentalises the problem,

> *I'm quite good a switching lives, so when I'm at work I'm at work and when I'm here (home) I'm here.* [Olivia]

Beverley errs towards forgiveness and compassion for Ben.

> *I've always said to him and still maintain it now; I will trust somebody until proven otherwise. We're together because I do believe we all make mistakes but I do believe you can turn things around and I suppose I'm waiting for him to turn things round.* [Beverley].

On occasions the majority of women resorted to strategies which allowed some form of distance or escape between themselves and their partner.

> *I'd go to bed and leave him to it* [Gemma]

> *I just wouldn't listen* [Gemma]

> *I prayed for help* [Christine]

Some women wondered whether their best method of self-preservation might be to leave.

> *I thought I don't think I would have stayed much longer if he didn't stop drinking.* [Fay]

Mary actually left and *"stayed with [her] sister"* after a couple of months sleeping on the sofa with their new baby. When she returned she introduced the rule, *"if he was going to get drunk then she did not want to 'see' it"*, which afforded some self-preservation. Christine also left home a couple of times and stayed with Colin's mother, but she would *"make sure everything was there [soups and food] if [she] wasn't about"*; so again, still *'being mother'*? Heather even separated from Henry for over a year, although she reveals that concerns for the children's safety and happiness were more salient than concerns for her own wellbeing. She reflected on whether having children precluded her from staying, or if she might have *"left him years before"* if she had no children.

In sum, the women seem to have developed a variety of protective strategies and some, particularly Olivia, appear incredibly resilient.

3.4.5 Feeling Isolated

As we have seen most women attempt to cope almost single-handedly with their problem drinker which leaves them vulnerable to loneliness. They are essentially left with a partner who is unable to provide love, support, or 'good' company.

> *I wasn't listening to what he had to say or what was coming out of his mouth because he doesn't even remember afterwards.* [Gemma]

Some women feel increasingly powerless, resentful and in some cases rather bitter.

> *I'd come home and he'd have his drinking chums round and they'd been drinking all day. I might fly into a rage, but not actually arguing, I'm not one for arguing, can't see the point really.* [Olivia]

Olivia talks about Oscar's *"drinking chums"* (note the disparaging language) in a way that signalled she felt like an outsider to Oscar in her own home. There are also hints of 'giving up' or maybe passive collusion as she *"can't see the point of arguing"*. She did not know about Al-Anon at the time; *"I think if I'd know about Al-Anon years ago, I would have gone".* [Olivia]

Mary expresses her feelings of isolation.

> *I felt that a lot of my colleagues had no time for me, so there wasn't much you know, I mean some people tried to help by suggesting things but nobody understands. Nobody really understood what the problem was and it was hard.* [Mary]

This is a time where partner needs help and support as they seem very fragile. The women also seemed exhausted, mentally and physically.

Ben's *"army"* of helpers (after his 'rock bottom') seemed to bring Beverley's isolation into sharp focus.

> *Ben was going to all the therapy and everything he had an army of people behind him helping yet ye'd he'd left a trail of destruction behind him, and I was a significant part of that trail. I felt completely isolated there was nobody, no phone calls, nothing.* [Beverley]

Beverley's extract was set in the context of generosity to Ben in that she had paid off his debts and had keep a roof over their heads, while he drank to excess and lost his job. The

"complete isolation" includes bitterness that his family offered no help or support, and even her father was cross with her for living with *"a waster"*.

This theme is intimately linked with *'others as a mixed-blessing'*.

3.4.6 Regarding Others as a Mixed Blessing

Given that the women's experience in the *'thick of it'* appears so distressing and isolating we might expect them to seek out or affiliate with family and friends by way of compensation or solace. Contemporary views of affiliation reveal greater complexity than was evident in the early work by Schacter (e.g. Schacter, 1959), who viewed people's tendencies to form bonds as almost universal across stressful situations. Psychologists such as Knight (2010) and Leary (2010) suggest that in stressful situations which potentially involve negative judgements from others, such as here, people errs towards privacy and greater selectivity. These views seemed validated by most of the women, as the prevailing sense is that of limited disclosure to a small number of trusted individuals. Further, there is a sense of the women's partnership with their problem drinker being their business and being linked with issues of loyalty.

> *Maybe I thought it would be disloyal to say anything [to anyone else].* [Olivia]

Olivia's *"maybe"* potentially undermines the possibility that she actually felt *"disloyal",* and I wondered whether Fay's explanation of similar selectivity (below) is 'stronger'.

> *I didn't want to expose the fact that my husband was [pause] worthless [because] that reflected on me – does that make sense?* [Fay]

Fay's exclusion of others was interpreted as an attempt to maintain her pride, and potentially a form of anxiety avoidance which allows some degree of denial. Conversely talking about Frank being *"worthless"* might make it 'real' as a kind of 'magical thinking'. In this way, limiting the involvement of others might be viewed as a subtle form of *'self-preservation'*.

Gemma and Olivia's extracts also contain elements of protecting their wellbeing.

> *Everyone kept talking to me, don't have him back, blah, blah, blah, and of course, I had him back cos it [him giving me a black-eye] was so 'out of the blue', I put it down to a one-off, [even though] I thought well this can happen again.* [Gemma]

> *At Al-Anon it's different because you're with people who understand, but to say something to someone who's never experienced it, the answer is well just leave isn't it, if you can't deal with something, if you don't like it …[but] things aren't that simple?* [Olivia]

Both Gemma and Olivia women want to avoid unwanted 'advice'. Gemma for example decides to *"have him back"* despite knowing this stance is 'at odds' with *"everyone"* else's beliefs that she 'should' leave. Similarly, Olivia does not want inexperienced others telling her to *"just leave"*. Such albeit well-intentioned advice from others to leave the problem drinker amounts to '*conditional* positive regard', or burdensome 'conditions of worth' (Rogers, 1961); this undermines the women's 'expertise' in their own lives. For example, Gemma's decision to *"have him back"* appears congruent and well-grounded as she takes a risk whilst acknowledging that it could *"happen again"*.

Whilst shunning the 'advice' of others does preserve the women's autonomy, agency and self-determination, it often leaves them isolated from potentially supportive social networks. This resonates with Olivia who elsewhere in her narrative revealed that the only person she confides in is her sister, who seems to accept that Olivia does not want to be told that she should leave Oscar. Similarly Gemma confides in a seemingly understanding, pragmatic, non-judgemental brother-in-law and his wife.

Fay's extract introduces a self-defeating tone?

> *I was completely on my own … my, my mother, I did confide in my mother, probably a couple of times, just broke down, but I'm not very good um at accepting help. She [mother] told my sister, with whom I've had a very, um difficult relationship, who did try to help – she did write to me and offered to lend me some money and I found it offensive.* [Fay]

Fay acknowledges that she is *"not very good at accepting help",* which can be interpreted as strength and independence and resonates with studies of altruism which suggest that some individuals view being offered help as rather demeaning, or even offensive as in Fay's case. Notably Fay takes some responsibility for her 'isolation'.

Heather provides a different slant on others as she battles for custody of the children during her separation from Henry. Heather became acutely aware that *"outsiders"* like *"the school"* viewed her situation very differently and favoured Henry, *"as he was good at putting on a credible front for others"*, while she was viewed as *"immature"*. Heather experienced huge frustration and a humiliating loss of trust in these professional others.

3.5 Superordinate Theme Four
'Reaching Rock Bottom': A dramatic shift

Nine of the ten women (bar Ruby) eventually experienced what they commonly referred to as *'rock bottom'*, which represented 'as bad as it got'.

For most of the women the journey to *'rock bottom'* was experienced as a gradual downward spiral from the *'thick of it'* where their partner's drinking, their interpersonal relationships, and the women's psychological wellbeing worsened, followed by a distinct critical point. Specifically, the drinkers' *'rock bottom'* involved acute situations such as near-fatal collapses (Colin, Henry), hospitalisation (David, Ben), suicide attempts (Oscar), critical rehab admission (Frank, Greg), self-referred to AA (Martin and Simon). These acute situations were sometimes exacerbated by additional stressful events like a fire in Henry's warehouse, Frank's financial crisis, and David's *"work-related stress".* For most of the women the drinker's *'rock bottom'* coincided with their absolute exhaustion, deep distress and often an inability to cope. I almost used Christine's description of *"total madness"* to entitle this terrible place; noting that this is the worst of previous 'rock bottoms' for her and Colin.

The following extracts describe the women's experience around the worst excesses of their drinker's journey.

> *I couldn't understand at all.* [Gemma]
>
> *I couldn't eat and lost weight, I got completely stressed out* [Christine].
>
> *Everything was going wrong [relationship and house problems] and I couldn't cope.* [Beverley]
>
> *My world fell apart … I was devastated … I was just lost … you begin to lose touch with reality.* [Beverley]

Many women had tried to get their partner to stop drinking, failed, and then almost waited for something critical to happen. Olivia however goes further and seemed to *will* Oscar to reach *'rock bottom'*. She would *"goad"* and *"provoke"* him in the hope that it would *"tip the balance",* and she voiced her disappointment that him disappearing to *"France wasn't it"* (see *'Being Mother'*). I sensed her exhaustion and powerlessness as she said,

> *At the end I thought my life's never going to change, it's always going to be like this unless I do something about it, but then, by that point it was reaching a critical point and it all changed anyway.* [Olivia]

We shall see in the following themes that Olivia is one of the women for whom *'rock bottom'*, after over 25 years of Oscar's serious drinking, signals the start of a new and positive life.

Sometimes, as in Sandra's case, the woman reaches *'rock bottom'* first. Simon's drinking escalated to the point she considered his behaviour *"reckless"* and morally *"totally unacceptable"*. He had become embroiled in what he called a *"business enterprise"*, which turned out to involve what Sandra considered to be very undesirable 'associates'.

> *This was crisis point, coming home and finding this 'undesirable female' in the house … I broke down* [Sandra]. Need to change this significantly

Although Sandra described her anger, she also expressed great sadness and regret at finding herself in such a joyless and uncomfortable situation. The row that ensued seemed to trigger Simon into seeking help from AA. Sandra's loss of temper over this situation stood in sharp contrast with the predominantly passive, unassertive, almost defeatist attitude that seemed to infuse the majority of her account. Sadly, unlike Olivia, Sandra's 'new' life seems more consistent with her unhappiness at *'rock bottom'* than any joy she may feel for Simon's abstinence.

Ben's *'rock bottom'* involved increasing his heavy drinking and drug taking whilst Beverley was on a working weekend. She came back to find Ben had collapsed and been taken to hospital. Beverley appeared quite traumatised by this acute situation.

> *I did have a nervous breakdown. I remember I was on the floor howling and I couldn't get up. I thought if I stay here long enough somebody will come and find me and put me in a padded cell and it'll be fine that's what I thought, I was really so close to going off the edge*. [Beverley]

Beverley's extract above conveys a vivid picture of almost total *"breakdown".* It feels very 'violent' as she howls on the floor, but also very child-like as she relinquishes self-control and hopes to be found and rescued. It becomes clear elsewhere that for Beverley the additional drug taking was considered even worse than Ben's problem drinking; consistent with Orford et al. (2001) for British PPDs.
She adds,

> *I think everything is overshadowed by the moment I found out the truth really [his drug taking] ... I thought it [our relationship] was a sham because he'd lied to me and covered up what he was doing.* [Beverley]

Beverley's children, especially Billy came to the rescue (Reid, 2009).

> *You've got to get on with it haven't you, I've got two children* [Beverley - stoical, does what she has to do]

Collectively the women's experiences of *'rock bottom'* resonate with the three major conceptualisations of stress: Selye's (1976) 'Stage of Exhaustion' within a physiological view (General Adaption Syndrome), with similarity to the 'Stage of Hysteresis' from the 'catastrophe model' of adversity (Carver and Scheier, 2002); Holmes and Rahe (1967) stimulus view of precipitating life events (in this case drink problems, illness, financial, accommodation and marital problems) and transactional views (e.g. Folkman and Lazarus, 1985; Folkman et al., 1986; Folkman and Moskowitz, 2000, 2007) which focus on individual appraisals of phenomenological experience. These associations and their potential implications for counselling psychology will be explored in the next chapter.

For some the initial sigh of relief immediately signals the start of a far less stressful and happier state of being; hence the only subtheme here, '*experiencing relief and positive emotions*'. The remainder of the women seem to bypass prolonged relief to find themselves living with a drinker 'in-remission'; this appears as relatively unchartered territory.

3.5.1 Experiencing Relief and Positive Emotions

Given the serious adversity (and near trauma for some, notably Beverley) that the women experienced in the *'thick of it'* and *'rock bottom',* we might assume that they now experience enormous relief and happiness. This however is only apparent for some, most notably Christine and Olivia. Christine for example spent much of the first half of her interview describing her current joy and enthusiasm.

> *Oh I am so grateful those days are over … He's always the 'Des' [designated driver] now so I go out feeling totally relieved knowing that I don't have to worry about it anymore, that he'll fall asleep, or anything you know, it's a good feeling, It's a <u>tremendous</u> weight off my mind … can go out and come back happy for a change* [Christine]

This extract demonstrates a flood of relief, pleasure and pride at Colin's 'return'. Christine also tells us she is *"so grateful"*, possibly in general, but maybe to Jehovah, as she and Colin are devote witnesses. Gratitude is becoming increasingly recognised as a powerful positive emotion (Emmons and McCullough, 2003; Emmons and Shelton, 2005) which helps to sustain a sense of wellbeing. Further, listening to Christine's joy and excitement resonated with Fredrickson's (1998) beliefs in the protective qualities conveyed by positive emotions and their value in broadening a thought-action repertoire. Christine clearly

enjoyed the pleasant and peaceful opportunity to contemplate the benefits of having Colin back.

In the following extract Christine seems relieved that others can also see his obvious improvements. Such visible signs of recovery might help the women compensate for the embarrassment they experienced as the *'social conscience'*.

> *Everyone who knows him (*knew about the problem) *say how well he looks and how bubbly he is. He's got his sense of humour back, is enjoying his work, enjoying golfing, fishing, entertaining ... different things that we do, you know.* [Christine]

I considered it important that Christine emphasises the positive consequences for him, whilst the *"entertaining" they* do is almost an afterthought. This conveys a sense vicarious pleasure, 'if he's happy, so am I', and may indicate that she considers him more important; reminiscent of *'being mother'* and possibly cultural discourses relating to women's role and place in relation to their men (Barker, 2013; Gill, 2006; Ussher, 1998).

Olivia also experiences relief but unlike Christine it appears to be relief for *he*r- self. The following extract is an expression of liberation from the daily grind of feeling responsible for Oscar when he was taken into rehab and looked after by others.

> *I now have the freedom of being able to think things through* [Olivia]

Olivia now has a partner who *"talks in a sensible manner"* and she hopes to have an easier life which includes reduced hours at work while *"he gets a job for a change"*.

> *More time for myself, which I've never had, go cycling … just the luxury of having some time to myself.* [Olivia]

This extract continues the thread of Olivia's self-care and her tone had almost a sensual quality while the word *"luxury"* 'oozed' with a sense of hitherto unavailable pleasures such as *"time"* for herself.

Ruby spoke of her *dreams* for Rays, whilst he continues to drink heavily but they seemed relevant to this theme. Ruby described a joint visit to the doctor where Ray had promised to give-up drinking,

> *I came home with wings on my feet thinking whey-hey!!* [Ruby]

I could imagine Ruby expressing similar happiness and relief to Christine if Ray ever keeps his promise.

I would imagine that the remaining women all experienced some degree of *'relief and positive emotion'* but this was either not particularly salient or long-lasting, or had been subsumed into the 'melting pot' that was the continuation of their lives. Other interpretations include the possibility that these positive states of mind were quickly superseded by a sense of trauma and betrayal (e.g. Beverley), caution (e.g. Gemma and Mary), or sadness and isolation (e.g. Sandra). These issues will be explored in the following 'dry' themes.

3.6 Superordinate Theme Five
'Resurfacing Reservedly': Taking stock

This location signals the start of an increased diversity of experience from the high degree of commonality in most previous themes. There are many indications that when the nine couples surface with a 'dry' problem drinker the women find themselves with time to reflect and take stock of their current reality.

Subthemes: Considering sunk costs; Re-visiting responsibility; Gaining Strength through Adversity.

3.6.1 Considering Sunk Costs

Given this contemplative phase of their journey the following analyses capitalise on the retrospective nature of the women's narratives to highlight something of the (sunk) 'costs' involved in remaining with a problem. The term 'sunk costs' originates in economic theory and refers to non-recoverable resources already committed to an investment project. It has a similar meaning in psychology in the domain of decision-making (e.g. Strough, Schlosnagle, Karns, Lemaster, and Pichayaothin, 2014) and is considered relevant to the women's considerations of remaining or leaving their relationship. Hafenbrack, Kinias and Barsdade (2013: 369) refer to 'sunk cost bias' as the "tendency to continue an endeavour once an investment in money, effort or time has been made", which underlies an escalation of commitment and/or entrapment.

All the women (and their partners) began making investments in their relationship from the point of commitment to each other. The women however, ending up 'sinking in' far more than their partners as the drinking problem progressed. The 'calculation' of such costs however, necessitated a distillation of individual narratives which errs their illustration towards prose rather than speech extracts. Unfortunately, given this word intensive approach to this subtheme I cannot do justice to the rich diversity of experience from all the participants, but hope that my selected accounts appear both insightful and credible. I start

with Ruby as her appearance post the *'thick of it'* is very limited given that Ray has not yet reached his *'rock bottom'*.

From Ruby's story I gather she married Ray at the earliest opportunity to escape her *"very Victorian upbringing and very sheltered life"* with her grandparents, while her widowed father worked. The marriage went against her father's wishes, although she voiced reservations about Ray, describing him as *"arrogant at first"*. However, Ray 'promised' excitement and difference so she made her first 'investment' to Ray. Ruby then became a social worker (now retired) whilst Ray progressed as an accountant (still working). They had two children, lived in idyllic country locations in England and abroad. Ray's drinking steadily increased over their 40 years together and now, in their 60's, they live almost independent lives; although Ruby professes to *"still being in love with him"*. In the meantime she experienced breast cancer (in-remission) and Ray's sustained (*"drink-related"*) infidelity, which she described as *"far, far worse than his drink problem"*. During our interview Ruby looked back at her happy times, and also looked forwards to maintaining the newly found freedom facilitated by Al-Anon philosophies and teachings.

So, Ruby's *'sunk costs'* include over 40 years of loyal and loving commitment to a relationship that, to most 'outsiders', may not seem worth the investment. She has experienced: the gradual loss of an equal status adult partner, particularly with respect to safeguarding her emotional security and being an engaged and caring co-parent; loss of trust and respect when he had an affair; and guilt and shame as she felt she'd *"let herself go and got fat"* because he didn't seem to *"see her any more"*. Ruby currently contemplates further 'costs' of being unable to leave him, because she still loves him; these include 'missing' him as a joint grandparent and as a companion in retirement.

Hafenbrack et al. (2013) might suggest that much of Ruby's investment was made within a state of mind that wandered from the past to the future, which increases the 'sunk cost bias'; whereas mindfulness of the *present* allows a more 'rational' consideration of further investment. The nine women apart from Ruby seem to have found greater peace of mind in the present, as they no longer worry so acutely over their partner's drinking. I argue that Ruby also takes a similar, yet distinct contemplative stance by virtue of re-gaining her sense of autonomy and self-determination with the help of her Al-Anon group.

To reflect, Ruby struck me as a warm, gentle, and dignified woman, who had decided, albeit with a rather heavy heart, that her 'best' way forward was <u>not</u> to expect Ray to join

her on her journey; if he did it was a bonus. This acceptance, or possibly resignation, lent Ruby a wistful strength and quiet determination with which she enjoys the 'here and now'.

Most of the remaining narratives told of similar sunk costs so I will now make a succinct attempt to both broaden the scope and highlight important individualities.

Christine for example, invested much to be with Colin, notably, a vibrant life in London as they set up home in a small Suffolk town which meant moving away from her close-knit family. Being middle-aged she will have grown up with a traditional view of married which 'assumed' a loyal wife would follow her husband. I heard some irony in her voice, however, as she said,

> *So that's how we're here in sunny 'Sudbury' [Christine]*

Sadly Christine also experienced a near-fatal road accident which left her unable to have children. Remaining with Colin, a fellow Jehovah's Witness, cost them both the chance of 'making good' this loss as they both accepted this situation as part of God's will. *I gained a sense of irony, unfulfilled expectations or even some lack of excitement from Christine, but also a deep sense of love, loyalty, and commitment.*

Mary stays, and continues to invest, out of a belief that Martin had experienced a difficult childhood and bouts of depression, so she remained to help him.

> *The only reason I stayed was because he needed me he knows he cannot survive, he knows how much he depends on me* [Mary].

This perhaps represents one of the mostly 'costly' relationships as it involves much self-sacrifice.

Similarly Olivia forewent an enormous amount on 'personal living' as she waited many years for Oscar to reach 'rock bottom' and stop drinking. She described making many sacrifices along the way, which included her *decision "not to risk having children"*. Olivia explicitly voices the sunk cost dilemma …

> *When you've invested a lot you are have basically two choices – keep investing in the hope it comes good, or cutting your losses* [Olivia]

As we know Olivia's investment eventually *"came good"*.

Beverley, who is distinct in that she described a distressing start to her relationship with Ben (first extract), as being her best friend's 'unwanted' husband caused great upset, only

to find that he, in her eyes, had betrayed her love and trust by developing a serious drink problem and falling into debt (second extract).

> *I was in a no win situation, either lose a friend or a potential partner, so I lost a good friend. There's so much damage there our friendship's gone for life.* [Beverley]

> *Everything we'd ever done was worthless to me and I can't trust him. He's left a trail of destruction and I'm a significant part of that* [Beverley].

Beverley had lots of plans and expectations and invested so much in Ben and he had effectively dashed her hopes. Consequently, much of Beverley's transcript seemed infused with a sense of being dragged into unfamiliar pessimist territory from which she was struggling to escape. There is also a sense of inevitability, 'I've made my choice so I'll try and make it work'.

3.6.2 Revisiting Responsibility

"Rock bottom' was a watershed for the nine 'dry' couples not least in terms of prompting both partners to revisit their respective responsibilities. In brief, the men come to realise that their drinking had become a problem and 'reclaim' responsibility, or are left with it by their partners (see Olivia's experience below). The women begin to relinquish much of their responsibility both for the drink problem and the excessive 'parental' responsibility they had accrued by *'being mother'*. However this distinction between the two partners masks the complexity inherent in the *two-way* interactions that make up a relationship. It can be argued for example, that the men had responded to the women's *'appeals to Dr Jekyll'*, as Fay said,

> *At last he conceded that he had a problem.* [Fay]

Similarly Mary tells us that Martin realised *"the penny dropped"* that *he* had to change. He gradually began to show more responsibility and self-determination which acted as a signal to Mary to *"back-off"* or 'detach with love' (Cutland, 1998) and also to trust in her belief that he had to make his own decisions. Further, Mary believes that Martin's love of his job fuelled his determination to stay stop drinking and stay 'dry'.

Simon's decision to stop drinking and take control of his own life again appears motivated by shame and fear for his sanity. Sandra tells us that he went to AA shortly after being caught bringing 'undesirable' others home, which she took as evidence that *"he'd gone mad",* and told him so.

> *He was so ashamed of himself and what drink was doing to his mind and his senses and his emotional life [that he went to AA for help].* [Sandra]

Gemma recognised that Greg was motivated to change and *"he wanted [her] to get help to help him"*. This is consistent with the clinical experience of those who facilitate joint involvement in working with drink problems (e.g. McCrady et al., 1999; Miller et al., 1999). Gemma agreed to have counselling and gradually realised that although she could be supportive, only *Greg* could control his drinking; these conclusions are consistent with interventions designed for PPDs in their own right (e.g. Howells and Orford, 2006). Gemma's realisation is echoed by others and conveys a sense of the women gradually gathering strength by knowing their limits, becoming more assertive, and believing it is right to relinquish 'extra' responsibilities.

Olivia provides a rich and compelling account of her how she found herself suddenly relieved of the responsibility for Oscar's well-being. She had rushed him to the doctor following a suspected suicide attempt. The doctor was just closing for the day and *"didn't want to know", s*o instead she left Oscar in a private rehab clinic and went home alone.

> *That was the sequence of events that changed everything. I just left him there, when he was telling me to go away. I was pleased just leaving someone else to deal with it. I felt I'd done my bit over the years and now someone else could sort it out. At that point there he decided he did want to do something about it and so far has.* [Olivia]

Olivia speaks for many of the women who seem to have decided upon a new regime and were adamant that that they did not want to go back, only forwards.

> *At that point, when he finally went into 'rehab' I knew it was never going to be the same if he came back and starting drinking again … I knew he could stop and it (drinking) was not going to carry on.* [Olivia]

Olivia's pivotal realisation is that Oscar knows how to stop drinking so she will *"never"* take full responsibility again.

3.6.3 Gaining Strength through Adversity

The re-balancing of responsibility explored above signals some movement towards a more functional and independent life for the women in this study. In retrospect however, a number of women have not only survived the worst excesses of their partner's drink problem, they appear to have '*gained strength through adversity*'. For example,

> *I'm a different person, hope I'm a better person, more caring person.* [Christine]

I believe this is a genuine and accurate reflection of Christine's state of mind at interview, and argue that her expressed desire to help others lay behind her participation in this study. This commitment to spread a positive message is also consistent with her religious faith and the philosophy of Al-Anon.

Olivia is more explicit about her newly discovered strength.

> *I told him, if he started drinking again I wouldn't stay around. I know he knows what he has to do to remain sober … before, I always thought if I left I was worried about his mental health, if he'd committed suicide, which he'd tried a couple of times, I'd have that on my conscience, because he'd think it was my fault, why did I leave. I thought if I stayed, I knew he was ill, I thought if I stayed and helped him minimise what was going on, it was better than leaving him to his own devises.* [Olivia]

This rich and illuminating extract reveals something of the 'binding factors', (e.g. evidence-based concerns about Oscar's mental health and suicide risk) that held Olivia in their relationship for *his* benefit, which resonates with *'being mother'*. Now she can spread her wings and may even 'fly away' if *"he started drinking again"*; this is powerful knowledge for Olivia.

Similarly Beverley' has begun to experience a change in her approach to Ben after the *"devastating"* losses to her sense of well-being following his *'rock bottom'*.

> *I've hardened up significantly [since rock bottom], much to his disgust* [Beverley]

Beverley's gain in strength *("hardening up"*) resonates with Joseph and Linley's (2005) arguments for post-traumatic growth. These authors formulate a rebuilding of independent self or new found strength, autonomy and determination after trauma. At the time of the interview Beverley was at a *"crossroads"* and typified a conflict between the old, give and tolerate self, and a new stronger self.

Heather expression of post *'rock-bottom'* strength relates specifically to her intolerance of *"<u>anybody</u> who needed to drink"*; and it extends beyond her interactions with Henry.

> *I've became very anti-drink, very anti it, anybody who needed to drink was disgusting in my eyes* [Heather]

Heather told me that she had subsequently *"softened her views"* but is still wary of occasions where she is in the company of heavy drinkers.

So it seems that if partners can weather the worst of the *'thick of it'* then the relationship can be re-built, but with the woman realising that she does not have to put up with the worst anymore; the worst has happened so it's a known quantity. This relates to tolerating anxiety rather than avoiding it, staying long enough to realise that it can be different, and *knowing* the there is life beyond a drink problem.

3.7 Superordinate Theme Six
'Navigating New Relationships': Life as a 'new' partner to a 'dry' Dr Jekyll

The pivotal interpretation in this superordinate theme is that neither the ex-problem drinker nor their partner would ever be the same people who had lived together previously.

Specifically, for some, their 'here and now' lives seem to convey huge benefits, explored in the subtheme '*positive future expectations'.* Others appear *cautiously* optimistic, hence the subtheme, *'one day at a time'*. A couple, most notably Sandra, experience significant ambivalence, even depression and appear to be *'living together apart'.* Again there is overlap, ambiguity and 'mess'.

A greater sense of commonality returns in the last subtheme, *'living with drink as the elephant in the room',* as the women contemplate their own drinking habits in relation to their 'dry' partner.

3.7.1 Positive Future Expectations

> *Oh I'm so grateful those days are over, I can't tell you Angela I can go out in peace"* [Christine]

Christine seems happy to resume a 'normal' social life with their friends her as says,

> *You've got to be positive that they'll stay in-recovery.* [Christine]

However Christine's "*got* to be positive" coupled with her and Colin's shared understand of pessimism act as optimism-rallying conditional imperatives and may lead to 'too much optimism'. Cherishing optimism and "banishing" pessimism may lead to under-estimating the risk of relapse and hence eventual disappointment (e.g. Ehrenreich, 1010a+b; Held, 2002, 2004, Sweeny et al. 2006; Sweeny and Shepperd, 2007a+b). The extract below provides further evidence of Christine's belief that the drink problem has gone for ever and she tells us she can cease worrying about it.

> *He's getting used to a life without alcohol. It just doesn't come into the equation any more. Now I don't have to worry about his behaviour* [Christine].

Christine's extracts needs to be read in the knowledge that Colin, unlike the other drinkers' in-remission, has experienced previous relapses and on the last occasion was acutely ill. I believe that Christine's experiences of relief and optimism, followed by deep disappointment and distress will have left a 'painful' mark on her. Cottman (1998) notes the enormous amount of uncertainty that remains even after partners appear to have stopped drinking. She believes they 'ask' whether it is safe to stop using strategies that have helped survival, and is it really the last time. These concerns must be very real for Christine and I believe she *does* worry about the possibility of relapse, but tries to rid herself of these 'forbidden' thoughts; often with the help of AA (and Al-Anon) philosophy.

> *As Colin's AA teachings say, we must banish 'stinking thinking'* [Christine]

Olivia also looks towards a very positive and happy future, although she reveals significant differences in her approach to towards maintaining her psychological wellbeing.

> *I thought, well that's finished (his drink problem) so I don't think back. To me it's as if it never happened. This new life has started.* [Olivia]

Olivia struggled to keep a small 'flame of optimism' alive for the time, as now, with Oscar's sober presence in her life. Given such enormous 'sunk costs', including foregoing the chance to have children, perhaps Olivia dare not open Pandora's Box in which I believe she keeps her regret and sadness. Essentially Olivia adopts a very future orientated stance for both of them, but especially herself, as she strives to *"make up for lost time"*.

> *I wanted a bit of life before I die, I wouldn't have gone on into my sixties* [Olivia]

So now Olivia seems to be embracing life.

> *Just any normal things that's what I enjoy now, go out for a day or maybe just go shopping. Other people might find it boring, but if you haven't done that for most of your life then it's a bit of a novelty, enjoyment of simple things.* [Olivia]

I believe Olivia is now listening to her 'organismic', experiencing self, which Roger's (1957; 1961) believed facilitated self-actualisation. She also seems motivated by intrinsic rewards (*"simple things, normal things"*) which are argued as evidence of a 'healthy' organismic valuing process (Sheldon and Elliot, 1999; Sheldon, Arndt and Houser-Marco, 2003).

Olivia's intrinsic 'drivers' stand in contrast to Christine's (above) which struck me as located more externally – cultural imperatives such as valuing optimism, not having '*to worry about <u>his</u> behaviour* (in front of others).

It can be argued however that being driven by internal or external motivations can inhibit *joint* enjoyment of these women's 'new' lives; Olivia may be preoccupied with her own pleasures and Christine may still be the *'social conscience'*, albeit a 'happy' one. I now look to Fay and Frank as a couple who, without being perfect, seem to have regained a sense of *togetherness*.

Both Fay and Frank have become increasingly interested in art, cultural experiences and music, particularly jazz. They also enjoy dinner together although,

> *We never go out for a drink, not because we avoid it but just because it's a bit boring for him really.* [Fay]
>
> *I've never felt I have to talk down or make things simpler (for Frank) [but] my first husband I did, that was big mistake. He was a builder and I kind of had this liking for a bit of rough I think, to be brutal about it.* [Fay]
>
> *I've always felt that he valued what I've brought.* [Fay]

A dialogue between Olivia and I bring us back to "love".

> *Me: You seem to have had a great deal of love for him I suppose?*
>
> *Olivia: I've always loved him, but for most of the time I've never liked him … and I'd think, what am I doing?*

Olivia seems to be expressing unconditional "love" for Oscar, not co-dependency which might traditionally have explained Olivia's staying under such difficult circumstances.

3.7.2 One Day at a Time

Some women, whilst allowing for the possibility of a less difficult future, were more cautious in reviewing their current position. The extracts from this theme appear more specific in comparison to say Christine's 'sweeping generalisations' seen above.

> *Hopefully we're on the other side of it now … he's already managed a sober conversation with his ex-wife.* [Gemma]
>
> *Yeah I mean I take each day as it comes at the moment, just to see, I think it's very early days ... At the moment it's a bit like treading on egg shells or testing the water … We're not out of the woods yet*. [Gemma]

We must remember that Greg is only recently in-remission and this might account for Gemma's cautious and pragmatic approach to his recovery.

> *I'm expecting him not to drink on Friday [with mates at social club] and I don't think he will because if he does he'll be letting himself down, [also] he'll be letting me down again and an awful lot of people know he's on detox* [Gemma]

Gemma's extracts resemble what could be termed 'cautious optimism'. Her stance struck me as cognitively active and reality-based in comparison to Christine's more 'static' and imperative-like encouragements. Gemma's optimism also appears more congruent and less illusory, and seems consistent with Peeters et al.'s (1997) characterisation of 'unrealistic optimism'. Unrealistic optimism was coined by Weinstein (1980) to define people's tendencies to believe that negative events (e.g. heart attacks, car accidents) are less likely to happen to them than their peers. Peeters et al. (1997) propose that such thoughts of resilience underlie peoples' adaptive inclinations to balance tendencies to both approach and avoid.

> *I'm not a risk-taker… I'm cautious* [Gemma]

Mary also appears quite cautious.

> *Things are alright now … this is life now, it isn't bad* [Mary].

Mary suggests that Martin probably started to think about moderating and then stopping his drinking because of work, rather than considerations for her or their relationship. Mary's stance appears relatively relaxed (contrast to Sandra's below). Also Mary understood Martin drinking at his father's funeral (after he had stopped drinking) – this was discussed and negotiated. This seemed like the 'right' thing to have done – he'd been honest, she'd been responsive and this seemed 'good' for the relationship. This raises the issue of appropriate stances in-remission.

Mary acknowledges that he has changed now he's 'dry', *"he's become a solitary animal"* (again this is very different to Sandra's 'dry' partner) but he remains her *partner*.

Denise seems to be continuing *'being mother'* and taking responsibility for maintaining David's sobriety; this demonstrates a lack of trust by not allowing David to 'find his own way' in recovery.

> *I am terribly suspicious now but only cos I've got to be to protect him"* [Denise]

Gemma looks back to look forward.

> *I would like Greg to do more himself in the evenings and perhaps we need to get out more together, because we haven't been doing that, he was coming home, when he was drinking heavy, 5 o'clock, come in the door, have a drink straight away. He has put a lot of effort into staying off the drink … He's a different person without drinking, that's why I think I got back with him the first time it all went pear-shaped (his angry exchanges with the landlord)* [Gemma]

Here I am reminded of a long-term bereaved client who tentatively began to think back to the worst of her grief, and began to appreciate how far she'd come; supervisory discussions viewed this as a sign of healthy recovery as it appears here. Gemma is also saying that Greg 'deserves' to have a better life now after his *"efforts to stay off the drink"*. Finally she refers to him as *"different … without drinking"* which implies in a positive way, which again stands in sharp contrast to Sandra's situation below.

3.7.3 Living Together Apart

The remaining *'new relationship'* seems the farthest removed from the enthusiasm and happiness described at the beginning of the women's journeys.

The essence of this subtheme is that the couple remain together but appear as two very independent individuals rather than two mutually supportive partners. This subtheme seems to 'belong' most evidently to two women in strikingly different ways. Firstly Sandra, whose narratives appear, infused with sadness, self-doubt, apprehension, and estrangement from Simon as they *'live together apart'*. Secondly Ruby, who, despite living with Ray's continued heavy drinking has, with the support of Al-Anon and Christian counselling, learnt to live her own life alongside Ray.

Simon, Sandra's partner, has been 'dry' for 5 years and has become an AA mentor which involves him being out of the house four or five times a week. This situation precipitates very mixed feelings for Sandra and raises important issues about the implications of one-person involvement in recovery programmes such as AA.

In the extract below Sandra appears to be struggling to find reasons to *be* optimistic, almost 'empty optimism' which seems sabotaged by her *"buts"* and disappointment at having unfulfilled optimistic expectations for something more exciting than just *"jogging along"*.

> *He is a much better person and I am very, very pleased that he has made such a wonderful, I won't say recovery, because that's the wrong word* ***but*** *I thought it would be two or three meetings at most and then he won't go,* ***but*** *he did. He's gone from strength to strength* ***but*** *this is five years hence since he had a drink* ***but*** *he's gone to the other extreme. I mean I'm not saying that we don't jog along,* ***but*** *it's a bit superficial … It's a long time to be leaving me when he goes to all his AA meetings* [Sandra]

Lyubomirsky et al. (2006) discuss such analytical thought on 'positive' events, like Simon's success at remaining 'dry' and 'giving something back' to AA, as being potentially damaging

to happiness and well-being. Sandra's next extract takes her deeper into her resentment and bitterness and away from any pleasure at Simon's success.

> *I do feel resentful that AA has taken over his life because he's been so successful! It's become his first thing. I have talked to him about it and he has said it is a very common thing for relationships not to last with couples in AA because the partner realises they don't know that person at all* [Sandra].

Here we see Sandra struggling to understand why she cannot feel happier in her relationship. She has even spoken to Simon about her unsettlement but he does not provide any solace, merely confirms her 'fears' and isolation. It seems that remission too can lead to a loss of *Dr Jekyll*. Following Sandra's narrative was at times sad and poignant as she reveals more of her current experience.

> *I'm going to get older and I question everything, I'm thinking what's going to happen? I think of the future with trepidation* [Sandra]

Sandra's story is infused with depressed thinking and what a CBT approach might identify as 'logic errors'.

Sandra believes that Simon had *"a calling"* which is good in the sense of him stopping but it also means that neither of them can 'own' the achievement in a personal sense? This lack of personal involvement or investment seems important for Sandra as her story develops a very reflexive quality towards the end. For example, Sandra talked about her ex-husband who was also an alcoholic and how she became very depressed because of his, or their, lack of quality of relationship.

> *I wasn't the cause of him drinking so he's sort of side stepped me, I know that's a bit irrational* [Sandra]

This extract seems to represent what Harré (2004) argues is our human tendency to 'think about thinking'. Here Sandra seems to have some insight into the unhelpful nature of her thoughts in that it represents a problem to her well-being. Much of Sandra's current unhappiness revolves around her age (Sandra is my oldest participant), her age-difference with Simon (who is almost 20 years younger), their respective wills, and with seeing no end to her current monotony. This pessimistic mood seems to have triggered self-blame verging on catastrophising.

> *What is it about me? I found two people the same. Am I attracted to people with a drink problem, psychological problems and baggage?*

This question conveyed heavy anguish and Sandra's tangible need for comfort.

> *He's found some reason for going on, and that reason isn't me".* [Sandra]

Paradoxically Sandra's story highlights the qualities of a happy relationship by describing what is missing; notable, companionship, investment (time and emotion), common ground, fun, a 'here and now' quality, and sharing. Sandra seems to distance herself from Simon by assuming that she cannot share in his success.

> *You know he did it by himself, but he would say that it was a call, some sort of power much stronger than yours* [Sandra]

Ruby, as we saw in *'considering sunk costs'*, has also distanced herself from Ray's drinking but in a way that allows her to enjoy her own life.

> *Life's opened up again thanks to Al-Anon. I've become me again, I do my own thing, I go on holiday with friends, drive on my own. I've learnt to play the flute it's not something I would have done before. I've just done so many things.* [Ruby]

Ruby's current stance struck me as very strong, positive and independent but not to the detriment of her readiness to embrace Ray's abstinence if it happens. This resonates with Thompson's (2004) reappraisal of the psychoanalytic concept of suffering which acknowledges happiness[14], like "common *un*happiness" as heavily determined by fate or circumstances beyond our control, whilst "neurotic misery is a creature of our own device" (Thompson, 2004: 141). So, like Ruby, we need the courage to face disillusionment and accept the possibility of disappointment so that we may embrace the chance of happiness if it comes along.

3.7.4 Living with Drink as the Elephant in the Room

Some women spoke of their worries about whether *they* 'should' continue to drink.

> *I won't drink because I don't want him to drink* [Gemma]

I gained the impression that these women were trying their best to be considerate and supportive, but this may also have raised concerns about 'tempting fate'. Gemma reinforced this possibility by describing how she very cautiously offered Greg a bedtime drink by deliberately asking if he wants a *"hot chocolate"*.

[14] The English term *happy* derives from Middle English *hap*, meaning chance (Thompson, 2004, p.151).

> *When I say to him, do you want a drink, I think I should be saying, do you want a hot chocolate, or do you want an orange juice?* [Gemma]

Gemma also described watching *'Antiques Road'* where someone had brought in a doll's house complete with miniature wine glasses. She remembered curbing her excited inclination to shout to Greg to come and have a look. It is as if *her mentioning* drink will *make him* want a drink; so-called magical thinking in CBT conceptualisations. In effect, such considerations skew their conversations and interactional dynamics which amounts to lack of congruence and 'being real'; *'drink becomes the elephant in the room'*.

Olivia and Christine adopt a rather different position to their lack of drinking.

> *I stopped drinking when Oscar stopped drinking. I always thought I was never meant to be a drinker* [Olivia]

> *I hardly drink at all now, and even in those days [before DP] I would feel it affecting me and I would stop, I would perhaps have a soft drink … I knew when to say I'd had enough, Colin didn't* [Christine]

Both these extracts attest to the ease at which Olivia and Christine can and do consciously moderate their own drinking. Olivia also told me that she and Oscar had drunk heavily together as teenagers and young adults but then *"you grow up and get a job"* and settle into work patterns which require a *"clear head"*. Unfortunately neither I nor Olivia could answer her question as to why Oscar had not followed the same 'normal', sensible path; or why Christine's Colin *"didn't know when he'd had enough"*.

Fay, at a very different place in this subtheme, spoke with great pride about Frank's habit of buying *her* an occasional *"good bottle of wine"*, opening it, sniffing it, *tasting it*, and passing it over to her for drinking; another example of her appreciation of (his) personal strength and determination.

She admits however, that Frank is unusual

> *He will buy my wine [sips and tastes it and says] that's a good one! You can see why one can say admiration is due. I think he's done amazingly well* [Fay]

In similar vein I conclude this chapter with Mary's praise of Martin's sobriety, whilst sensitively acknowledging his rather sadder 'new' life, and the apparent neglect of her role in his social world.

What I do now [he's dry] is give him lots of praise, say it's great cos he still has friends who like a drink and it's affected his social world – he's become a solitary animal. [Mary]

Chapter Four: Synthesis and Discussion

4.0 Overview

This research was developed out of a concern to understand and ultimately help individuals embroiled in the adversity of a *partner's* problems; in this case a drink problem. This research brought together ten women as 'experts' in their shared experience of living with a problem drinker. Their accounts were analysed via IPA to gain understanding of how they interpreted their lives, and maintained self-regulatory processes of wellbeing in the face of this particular adversity.

The majority of women seemed motivated to believe in their partner as *'Dr Jekyll'* throughout the journey from the *'creeping onset'* to *'rock-bottom'*. The final themes explored their attempts to navigate a new, 'dry' relationship upon re-emergence of their familiar, much-loved partner; although, as we have seen, this belied a more complex experience.

The women's accounts also raise complex questions concerning the balancing of wellbeing of an *individual* who is also a partner in an intimate *couple*. This chapter will explore issues relevant to maintaining relationships under challenging circumstances, and issues concerning the stability and quality of relationships. Accordingly, a primary aim for this chapter is to provide insight for counselling psychology which might benefit PPDs in their own right, and as an intimate partner.

Epistemological and methodological considerations form part of later discussions in order to evaluate the credibility and rigour of this research. This chapter also provides potential avenues for further research and interpretation.

4.1 Synthesis of Findings: A Platform for Therapeutic Intervention and Counselling Psychology

The synthesis of findings in this chapter will follow the journey the women seemed to navigate as their partner's drink problem evolved. At each location (superordinate theme) I present a cameo of the main features and themes, followed by a dynamic, responsive platform for therapeutic intervention. Strawbridge (2006) argues that the widely accepted aim of counselling psychology is to provide psychological therapy for the alleviation of psychological distress and the development of self-understanding. As professionals we

claim competence in specialised knowledge and skills pertinent to this aim. In turn, this knowledge bestows power which requires professionals to put aside self-interest, act in benevolent ways towards others, and accept the need to provide ethical practice. So, in the spirit of George Miller's belief that psychology can only be of use if it can be 'given away', I offer summaries of the personally and psychologically embedded findings from Chapter Three, followed by potential guidance and stances which might benefit counselling psychologists.

All synthesis and discussion is data driven and is sensitive to both common themes and individual difference, which is entirely consistent with the ethos of the IPA analysis (Reid et al., 2005; Smith, 2004). Specifically the model in Figure 4.1 provides a schematic representation of the 'double hermeneutical' process that guided my interpretations of the women's interpretations.

4.2 Introduction to the Model: Personal and Relationship Dynamics with a Problem Drinker

Firstly this model is used as a vehicle from which to explain the frameworks and ingredients of the interpretative process once I had 'unbracketed' existing literature, my experience as a practitioner psychologist, and my subjectivity as a fellow partnered female. In other words, it draws together the epistemological underpinnings and aims of this IPA analysis, rather than seeking to model the findings per se. It facilitates the process of 'unravelling' the relationship between what people think (cognition), say (account) and do (behaviour) (Smith, 1996).

Specifically, my interpretations were embedded within the following considerations:

First and foremost I place myself beside the participants, who, in turn, are beside their partners. Both partners bring their unique personal, psychological, socio-biographical and cultural selves to their relationship ('relationship characteristics and individual differences'); they create a co-joint 'reality', the journey. These predominantly intra-psychic factors are then mediated in interaction with 'relationship interactional processes' (such as communication, conflict and coping behaviours, emotional responses) and together create the sense of 'personal and/or relationship satisfaction', which errs the individuals to remain or leave. In reality, partner interactions are envisaged as a moment-to-moment process, as described by Levitt, Butler and Hill (2006), although my analyses can only provide 'snap shots' of these.

The basic structure for this model is an adapted version of the marital satisfaction pathways developed by Rosen-Grandon et al. (2004), in conjunction with Cranford et al.'s (2011) interactional stance, predicated upon the Vulnerability-Stress-Adaptation Model (VSAM, Karney and Bradbury, 1995). Accordingly, it embraces 'linear' and 'circular' *processes* throughout (Schröder, 1991) rather than static markers (Clark and Lemay, 2010). The occurrence of the drink problem is viewed as a 'moderating variable' (Rosen-Grandon et al., 2004).

In sum, the model is predicated on the belief that the women's understanding of their lived experience is influenced by psychological processes of complex, dynamic and multifaceted origin. The result of this rich interwoven complexity comprises the women's understanding of their everyday lives, within their personal, social and cultural discourse milieu. This diversity is consistent with the need for counselling psychologists to be cognisant of a variety of counselling and evidence-based approaches to client work.

The drinker is represented on the diagram as a smaller entity as I cannot know his phenomenological world in the same was as his partner. The women do occasionally provide glimpses into his world, at such times it feels like involvement in a 'triple hermeneutic'.

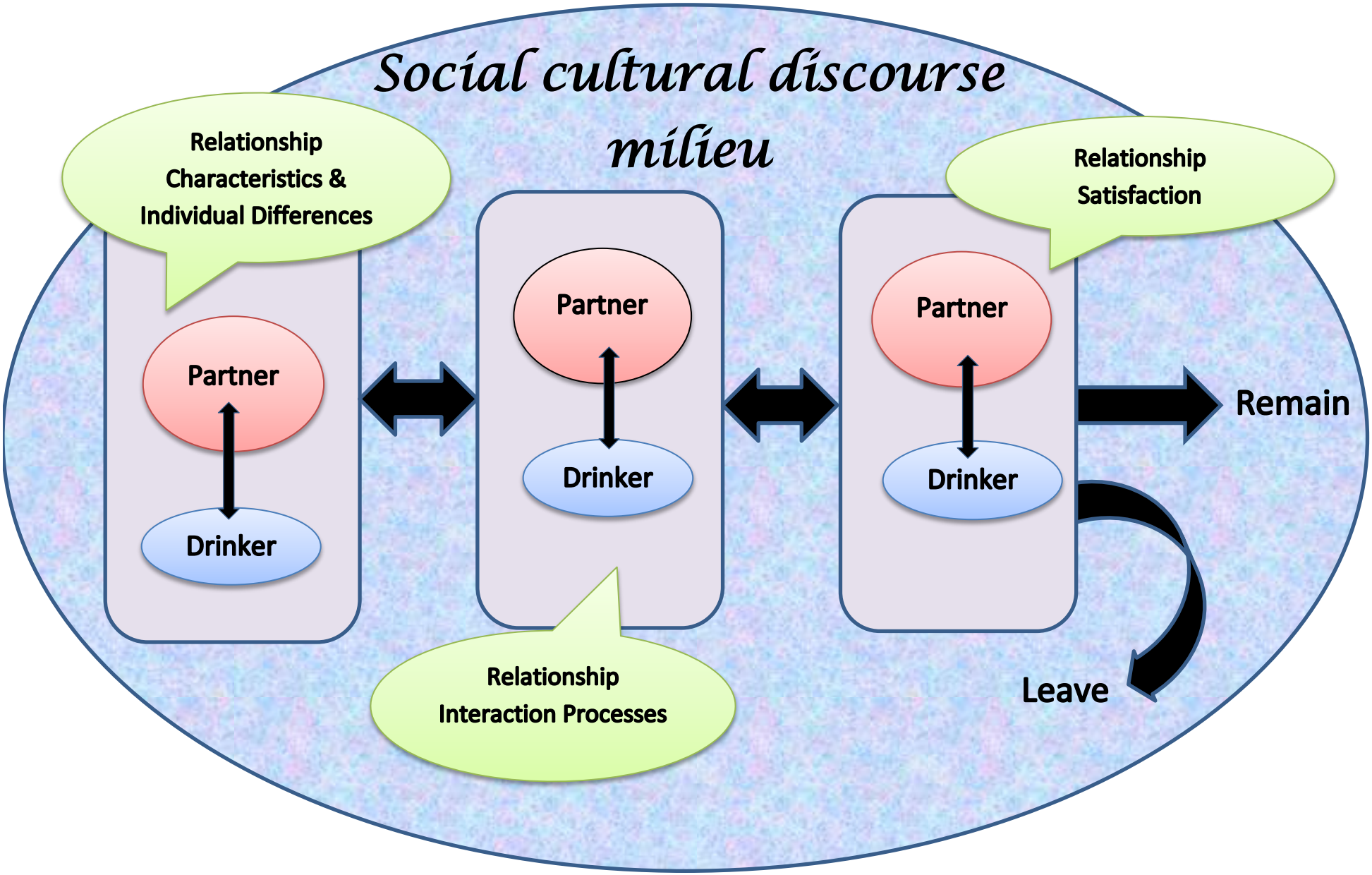

Figure 4.1 Personal and Relationship Dynamics with a Problem Drinker

4.3 The Drinker's Path as Partner's Adversity and Challenge

The women's narratives were strongly evocative of a journey, whose direction seemed largely determined by her partner's problem drinking. There were 'crossroads' however, most notably post *'rock bottom'*, at which the women appeared to reassert their own needs towards self-determination. This journey is discussed and synthesised below. Throughout I attempt to differentiate between those aspects of the women's meaning-making which signal adversity, and those which might be understood as challenge and eventual growth. The journey starts in the 'neutral territory' of the pre-problem drinking days.

4.4 Superordinate Theme One: Life Before the Drinking Problem

Subthemes: *Halcyon days; counting blessings; considering causes.*

The women's journey began in the 'normality' of two people meeting, becoming attracted to each other, and forming a couple with the expectation of a joint long-term intimate commitment (Bubenzer and West, 2000). Relationships are complex, dynamic "arena[s] which ha[ve] the highest possible scope for pain and distress, as well as pleasure and fulfilment" (Barker, 2013: 1). All of these aspects feature in the narratives of this research; they begin with the positive in the first two subthemes, *'Halcyon days'* and *'counting blessings'.*

It seems that most of my participants referred to similar aspects of their notions of self and partner to position themselves as happy, rational, loyal, and loving partners of yet-to-be problem drinkers. Specifically, these women appear to value the materially comfortable lives they have lived, *"smart cars"*, *"expensive foreign holidays"*, *"beautiful homes"*, but also interpersonal 'blessings' like companionship, having a *"soul-mate",* or a *"tonic"*. It seems these women predominantly position their early relationships within optimism and positive expectation.

The remaining subtheme in the pre-drink problem location, *'considering causes,'* saw most women allocate responsibility for the problem drinking to factors beyond their partner's control (e.g. genetics, work-stress, drinking cultures). This positioning allowed the women to distance both themselves, and importantly their partners from personal responsibility for the drink problem to come. Similarly, most of the women avoided the diagnostic term alcoholism or alcohol dependence, seeming to prefer more ambiguous references to *"the problem"*. This

finding can be understood in relation to the potentially stigmatising or pathologising of those involved in experiencing difficulties such a problem drinking (Ussher, 1998).

Apart from the overarching positivity, the most noticeable finding from this early point in the couples' journey is the *lack* of commonality. All ten women and their respective partners seemed to inhabit their own 'normal', conjoint 'reality'. Their journeys started from different 'places', in differing circumstances; each partner bringing their own individual, social and cultural history, and their unique 'everyday' personality to their relationship (Allport, 1946; Dumont, 2010).

The relatively sparse theorising about relationships suggests that similarity (rather than complementarity) on a range of personal qualities (e.g. attractiveness, age, education, religious, political views, even alcohol use, Rimmer and Winokur, 1972) is considered responsible for the initiation of most intimate relationships (Clarke and Lemay, 2010; Hulson and Russell, 1991; Kelly and Conley, 1987; Tyler, 1988). Except for drinking behaviour, aspects of similarity were not explicitly explored. All couples shared the similarity of coming from a 'normal', social-drinking culture, even Olivia and Oscar who met as adolescent drinkers. However, as we will see in the *'creeping onset'*, the couple gradually become dissimilar in this respect and it becomes a key mediator of the women's increasing difficulty in maintaining a relationship with their partner.

4.4.1 Counselling for 'Normality'

Referring to women's narratives, their partner's drink problem seemed to grow out of an earlier joint enjoyment of social drinking. Essentially the men carried on drinking, often with other males in the pub, so-called 'pub-culture' holds more relevance for men (Orford et al., 2009b). The women increasingly stayed at home trying to cope with domestic chores and/or the children. Holmila (1988, 1994, 1997), even concludes that wives take responsibility for controlling men's excessive drinking as part of their conjugal role. From feminist and emancipatory perspectives (e.g. Ussher, 1998) we might argue that female partners of a problem drinker face greater burden, responsibility, shame, and self-blame by endorsing cultural ideologies related to the traditional roles of women (see also Barker, 2013; Graham, Sorrell, and Montgomery, 2004; Kahu and Morgan, 2007; Vincent, Ball, and Peitikainen, 2004). I, like my fellow middle-aged participants grew up in the 60's and 70's when such traditional values were relatively undiluted by more contemporary views promoting, 'women can have it or be it all' (e.g. Barker, 2013) or are expected to 'be it all' ethos (e.g. Ussher, 1998).

This resonates with my own upbringing where my father was always treated as the most important partner. He was the breadwinner (a police officer) and had to be 'waited on' and 'protected' from the hassle of daily life or dealing with children; particularly when he returned home from a night shift. My mother was the home-maker, but she also exuded an air of selfless 'subservience'. This resonates with the 'resistance' of some clients to 'listening to' their own needs, as they equate this with being selfish. As Barker (2013: 2, underline added) observes, "couples today are generally composed of two independent people who have <u>their own</u> dreams and goals", a desire for personal fulfilment. This can create tension as partners balance individual needs, with their motivations to sustain a relationship.

Returning to the women's accounts, humanistic approaches to counselling might view the women's valued goals and blessings as indicative of the motivational influence of their 'organismic valuing process' (OVP). Sheldon et al. (2003) for example, argue that erring towards goals with intrinsic value (seen here as joint enjoyment of life), and away from goals with more extrinsic value (e.g. financial success, status symbols, and expensive property), signals a healthy functioning of the OVP towards self-actualising. Further, intrinsic motivation is viewed as more consistent with self-concordant goals which promote more sustained effort (Sheldon and Elliot, 1999). We saw how these women's main priority became maintaining contact with their *'Dr Jekyll'* as he 'battled' with '*Mr Hyde'*, hence their tenacious and sustained efforts in the *'thick of it'* to protect their relationship.

Again, the participants were middle-aged, and for half of them their problem drinkers were not their first sole partner. Accordingly, they may be more motivated towards goals such as 'togetherness', and have the maturity to appreciate that material wealth and possessions are only part of being happy in later life. This resonates with a growing body of literature which argues that money and status ultimately do not make people happy (e.g. Ahuvia, 2008; Miller, 2001; Myers, 2000). Older individuals appear to recognise the shortfall of material trappings of life by demonstrating an almost spiritual sense of acceptance of life's adversities and an ability to experience intrinsic pleasures in the 'here and now'. Jopp and Rott (2006) even found *centurions* remarkably happy, in spite of reduced financial circumstances and significant health issues. Middle-aged maturity is also indicated in the women's tenacious and multifaceted coping efforts in the *'thick of it'* as we shall see later.

Of note, the women's accounts are retrospective, which I suspect led to some positive distortion of their narratives for the purposes of positioning themselves. Taylor and Armour (1996) posit such illusions as an integral part of their 'cognitive adaptation theory of stress and illness', and are to be encouraged. In contrast Jahoda (1958) was the first to argue that

individuals need to re-orient themselves 'back to reality', after experiencing self-enhancing illusions that often sustain them through adversity and serious illness. For my participants, it would seem inappropriate, even potentially damaging to suggest that their 'rose-tinted' views of the past should be abandoned in favour of a more congruent perspective. Rather, I suggest that these women have, to differing extents, reconstructed their own history such that it forms an important part of their resilience in currently remaining with their problem drinker. As counselling psychologists, and researcher in this instance, it is important to understand and respect such strategies, and also trust in people's self-determination and agency in difficult situations.

Problems may arise however, if unrealistically high optimism or illusion were being relied upon for sustaining well-being. Both Tomich and Helgesen (2006), and Pinquart, Frohlich and Silbereisen (2007), suggest limits to Taylor and Armour's model in terms of the functional value of extreme illusion. Further, an increasing body of literature suggests that extremes of optimism can be as potentially damaging as extremes of pessimism (Ehrenreich, 2010a+b; Gruber, 2011; Gruber et al., 2008; Held, 2002, 2004; Peeters et al. 1997; Sweeny et al. 2006; Sweeny and Shepperd, 2007, a+b). Excessive pessimism seems firmly associated with depression (e.g. Beck, 1967, 1995) and 'learned helplessness' (e.g. Abramson, Seligman and Teasdale, 1978; Maier and Seligman, 1976). I argue that extremes of optimism are consistent with mania (ICD-10), and that a balance of 'positive' and 'negative' factors is most functional for well-being (Bradding, 2007). In a therapeutic setting, "counselling psychologists should listen to and accept people's fears and insecurities as well as celebrating their achievements and feelings of contentment" (Boyle, 2007: 291).

4.5 Superordinate Theme Two: A Creeping Onset

Subthemes: *Being the social conscience; Becoming weighed down with worry.*

At some point in the couple's relationship the dynamics started to change. All the women (Fay and Denise to a much lesser extent) begin to notice that their partners were drinking more heavily, often covertly, and becoming drunk very quickly. They also seemed to be *"behaving badly"* [Sandra] in company, and becoming violent and abusive privately. The women's narratives revealed embarrassment, consternation, and increasing worry. Consequently, the period of *'creeping'* realisation precipitated a variety of thought processes, emotional responses, and attempts to remain with their problem drinker under increasingly troubling circumstances.

The most noticeable aspect of change was an inequality in enjoyment, which reflected increasing disparate stances towards drinking. Specifically, the woman became monitors or observers of their partners in a social context (either external and 'real', or internal as a form of 'mind reading' of others), rather than congruent experiencers of their own phenomenal worlds. Effectively the women acted as the *'social conscience'* and *'became weighed down by worry',* whilst their men seemingly enjoyed themselves; although this tentatively ventured conclusion for the problem drinker is debateable. Having only interviewed the non-problem drinking partner, the drinker's perspective falls outside the parameters of IPA's double hermeneutic. Interpreting the women's experience effectively masks much of their drinker's perspective such that we cannot know what caused his drinking behaviour to change. Some narratives however, allude to insecurity or unhappiness on his part, and/or his responding to perceived changes in his partner's stances and interactions.

Systems theory approaches to relationships argue that each person is uniquely and significantly enmeshed in the *dynamics* of a relationship, so any outcomes are jointly created (e.g. Bennum, 1991; Vetere, 1998). Consequently, a change in one person can precipitate unsettlement or even 'crisis' (Hinchliffe, 1991), which signals 'recalibration or reorganisation' in interactional systems (Bennum, 1991). Change causes uncertainty and anxiety which, according to Barker (2013) inclines us towards the 'safety' of rules. This seemed evident for my participants as they clung, almost defensively, to stereotypes of alcoholics which did not resemble their partner (like Christine's *"tramps with dirty raincoats"*), or denial as this *"couldn't be happening to me because …*" Essentially these women's partners were breaking the rules of fairness (Janoff-Bulman, 1992, 1999) and 'just' expectations of relationships (Hulson and Russell, 1991).

4.5.1 Counselling for Congruence and Agency

Although 'rules' provide some degree of security or goals to aim for, they also imply there is a right and wrong, often do not work, amount to fixed 'conditions of worth' (Rogers, 1957), and effectively exert pressure to live by culturally prescribed dictates (Barker, 2013). In essence, "the pressure to be normal constrains people and leaves them anxiously monitoring for any sign they might not be normal" (Barker, 2013: 3); this conclusion might help to explain the theme '*becoming weighed down by worry'.*

The women seem to increasingly refer to social rules, rather like 'conditions of worth' (Rogers, 1961) and potentially neglecting parts of their selves, thus restricting unencumbered personal expression. Effectively the women are the 'Me' (the self-as-known,

including as a partner) in the relationship, and the men seem to languish as the alcohol fuelled 'I', which provides a flow of experience. Consequently, the women experience embarrassment and worry, and increasingly live a socially impoverished and unhappy life. In essence, the women become increasingly concerned and insecure with their partner's behaviour as it represents a threat to their expectations and understanding of their relationship, and their concept of self.

People have strong 'normal' everyday tendencies to search for meaning and to make sense of their worlds (e.g. Allport, 1946; Bartlett, 1932). Sometimes however these processes lead to assumptions and interpretations that can be recognised as dysfunctional or precipitate unpleasant experience; as in this unsettling phase of the drink problem where embarrassment and increasing distress predominate. Contemporary approaches to therapy such as Rational Emotive Behaviour Therapy (REBT) are predicated upon rational meaning-making and decision-making as the basis for well-being in the face of adversity (e.g. Dryden 2003, 2011). REBT encourages clients to engage in a number of intentional strategies or aim to foster certain qualities that enable them to deal with difficult situations. Flexibility of thought, non-awfulising, tolerating discomfort - predominately anxiety (see Dryden, 2009) and uncertainty (Bar-Anan, Wilson and Gilbert, 2009; Wilson, Centerbar, Kermer and Gilbert, 2005), acceptance, self-motivation, self-disclosure, resilience and self-control are viewed as particularly useful. Many of these issues will be discussed more fully in later sections.

Research findings suggest that non-concordant couples (only one problem drinker), as in this study, experience greater unhappiness and marital dissatisfaction than concordant couples, where both either drink or abstain (e.g. Floyd et al., 2006; Gomberg, 1988; Leonard and Rothbard, 1999; Moos et al. 2010; Wilsnack and Wilsnack, 1991; Wilson, 1980). In fact Roberts and Leonard (1998) coined the term 'drinking partnerships' to convey the sense of equality of experience and enjoyment in concordant drinkers. Additionally, a number of studies have demonstrated the seemingly damaging effects of dyadic conflict which results from one partner's drink problem (e.g. Halford and Osgarby, 1993; Jacob et al., 1983; Kahler et al., 2003; Moos et al. 2010; O'Farrell and Bircher, 1987). These researches strengthen the case for the centrality of inequality of experience in partner distress, which may mediate a cycle of further dissatisfaction.

The above disharmony, stemming from difference, may signal gradually increasing self-discrepancies, which William James, Sigmund Freud and Carl Rogers all refer to as important 'mediators' of unhappiness. Self-discrepancy theory (Higgins, 1987; Higgins, Bond, Klein, and Struaman, 1986) has been endorsed as a platform for exploring differential

emotional experience and wellbeing (e.g. Chang and Sanna, 2001; Hardin and Leong, 2005) and implicated in sustaining recovery from alcohol misuse (Shineborne and Smith, 2009). It seems that discrepancies between 'actual', 'ideal', and 'ought' selves mediate negative emotions (Hardin and Leong, 2005) and (two-dimensional) pessimism (Chang and Sanna, 2001). I argue that most of my participants were responding to perceived discrepancies between their 'real' selves, which were becoming increasingly unhappy and insecure, in relation to their 'ideal' or 'ought' (relationship) selves, which are heavily 'rule-bound'. Barker (2013) advocates staying with the uncertainty, leaving the rules behind, and developing your own rules; consistent with a Rogerian approach to growth and self-actualisation.

In effect, any pre-existing equilibriums were becoming tested and increasingly erring towards disequilibrium and crisis (Hinchliffe, 1991) or 'hysteresis', in catastrophe theory models (e.g. Scheier and Craver, 2002). The women experienced a gradual shattering of assumptions and expectations, predominantly about their partner and their relationship, which worsen in the *'thick of it',* and eventually come to a head at *'rock bottom'*. Decreasing self-discrepancies then is viewed as an important aim for individual therapy, but can also be highly relevant to couple therapy.

Whilst not advocating that 'sober' partners match their partner's drink problem to derive the 'happiness' of concordant drinking, it is worth considering whether they might benefit from paying more attention to their own enjoyment. This might reduce their *'worry'* about how they presented as a couple, or what their partner's drinking 'said about them'. Additionally, we saw the women increasingly unwilling or unable to share meaningful conversations; such lack or discrepancies of self-disclosure is viewed as potentially problematic (e.g. Davidson, Balswick and Halverson, 1983). A therapeutic 'solution' would involve facilitating communication, responsiveness, and mutual unconditional positive regard; this way the couple would validate each other's need for acceptance and freedom from the judgement of others.

In sum, with or without a drink problem relationships change and need to be negotiated and navigated flexibly for the well-being of both partners; this highlights the normality of coping. Trusting in one's own instincts, maturity, and resilience allows an individual to consider changes in a partner's attitude and behaviour flexibly, as a challenge to the relationship, rather than a threat (Folkman and Lazarus, 1885).

4.6 Superordinate Theme Three: In the Thick of It

Subthemes: *Losing Dr Jekyll and living with Mr Hyde; Appealing to Dr Jekyll; Being mother; self-preservation; feeling isolated; regarding others as a mixed-blessing.*

At this location, *'losing Dr Jekyll and living with Mr Hyde',* the women are in no doubt that their partner has a drink problem. They are rapidly losing their familiar, loved, and valued partner, and becoming increasing distressed and *'feeling isolated'*. Consequently, in the *'thick of it',* the women conveyed a strong sense of just trying to cope with the day-to-day rigors of living with a problem drinker, the demands of which were many and various.

Three broad directions for the women's coping efforts were identified. The themes *'appealing to Dr Jekyll'* and *'being mother'* were most prevalent and the women focused their seemingly well-intentioned efforts on the problem drinker. *'Appealing to Dr Jekyll'* is characterised by attempts to confront and change the problem drinker such that he moderates and ultimately stops drinking altogether. *'Being mother'* characterises the women treating the problem drinker as an adult child. This involved teaching or disciplining their 'child', alongside providing support and comfort, and sheltering them from harm. The women also take burdensome responsibility, not only for trying to control their partner's drinking, but for most aspects of their joint lives. This inequality of responsibility may provide some comfort that tasks are done, but at a cost to the women's 'free-time' and mental well-being (e.g. Ussher, 2000). The remaining coping theme, *'self-preservation'*, involved maintaining personal well-being, with strategies that ranged from quiet contemplation and praying, to physical separation from their drinker.

Collectively, the women's approach to attempting to cope with a problem drinker is mixed and multi-faceted, even to the point of using potentially contradictory or counter-intuitive strategies (e.g. Orford, 1998). The themes did not appear in any particular order and were used variously by all of the women. This ambiguous diversity however is to be expected in the 'messy' and difficult lived experiences of a PPD.

The other noticeable aspect of the women's coping efforts is that they were relatively solitary. This may be due partly to coping becoming increasing time-consuming, but also to an apparent reluctance for the women to seek help from family and friends; hence the theme *'regarding others as a mixed-blessing'*. In other words there seems a lack of affiliation (Leary, 2010). Affiliation is a two-way "process whereby [people] orient towards sharing bonds" and developing connections with others who share values (Knight, 2010: 39). Early

experimental work on affiliation (e.g. Schacter, 1959, cited in Leary, 2010) concluded that bonding with others in stressful situations can lead to positive outcomes such as gaining social support, comfort and security (Leary, 2010).

More contemporary and ecologically valid research into affiliation has suggested that people prefer not to affiliate in stressful situations in which "the presence of others raises concerns with social evaluation or increases the possibility of embarrassment" (Leary, 2010: 864). This caveat seems to resonate with the women's sensitivity to the perceived or imagined judgement of others, which caused embarrassment and distress in the *'creeping onset'*. Preferring reticence is also consistent with their realisation that discussing their partner's drink problem with others who do not share the same values, or understand their situation, may risk further embarrassment, stigma and potential shame (Ussher, 1998; Van Vliet, 2008; 2009). Further, some of the women, Fay, Olivia, Gemma and Mary particularly, preferred to distance themselves due to be a belief that friends or family members would (or had) simply told the women to leave their drinker. In person-centred terms this amounts to *conditional* positive regard and undermines the women's self-determination and security.

In sum, the *'thick of it'* represents a tough and increasingly isolating challenge to the women's ability to cope, and hence stay with their problem drinker.

4.6.1 Counselling to Facilitate Coping and Connection with Others

Introductory literature recognised the need of many PPD's to know how to cope with their problem drinker, and how best to help encourage them to stop drinking (e.g. Copello et al. 2002: McCrady et al, 1999; Miller at al., 1999). All the women in this research seemed similarly motivated, and all bar Ruby saw their partner achieve their desired outcome. This extraordinary success however, belies immense complexity and ambiguity such that there are no simple answers to offer to counselling psychology. Instead, I present some synthesis of this complexity for guidance, but also suggest, like Howells and Orford (2006: 56), that each individual or couple, "have distinct and unique patterns of interrelating" so need to be treated as unique experts in their own lives.

The first potentially contradictory message emerges if we synthesis the two most prevalent coping themes derived from this research, with alcohol-specific coping formulations. *'Appealing to Dr Jekyll'* and *'being mother',* seem consistent with 'confrontation and control' strategies (Kahler et al., 2003), and the 'engaged' strategy identified by Orford et al. (2001). In turn, confrontation is the final 'pressure' in Barber and Crisp's (1995) 'pressure to change'

technique, for PPDs to help their as yet 'unmotivated drinkers' to acquiesce to treatment, which accords with the success of Miller et al's (1999) confrontational intervention for the same purpose. Miller et al.'s (1999) Johnson Institute Intervention (based on confrontation) achieved the highest success rate (75% of those who used this technique saw their drinkers into therapy) compared to the Al-Anon (13%) or community and family based interventions (63%). The 90% 'success rate' in this research also indicates the value of engaged and confrontational stances for PPDs.

However, Miller et al. (1999) found their PPDs very reluctant to use confrontational strategies (only 30% chose to use them), preferring the more supportive or acquiescent approaches. This reluctance to engage in confrontation was also recognised by Kahler et al. (2003) as 'avoidance of confrontation' and consistent with 'tolerant-inactive' strategies (Orford et al., 2001); however, both of these essentially avoidant strategies were associated with greater marital distress, conflict and unhappiness. It is important to note that 'engaged' and 'confrontational strategies' are also found to be associated with conflict and distress in marital relationships (Kahler et al., 2003; Orford et al. 2001). Maybe the women here, who persisted with confrontational tendencies, put their own needs as secondary for the benefit of their partner (as indicated by *'being mother'*). Or perhaps the tenacity and courage required to confront their partner 'buffered' against excessive distress long enough to facilitate their drinker's decision to stop drinking. Certainly my participants seemed highly motivated to help their problem drinkers, and eventually saw them stop drinking. This may have been construed as adequate compensation for the previous marital hardship and dissatisfaction.

Clark and Lemay (2010) posit a mutual, but not necessarily symmetrical, process of responsiveness as the key to close relationships. This might both explain and validate the women's tendencies to persist in their confrontational and controlling stances as a response to decreased responsiveness from their partner. This persistence implies belief in the value of maintaining investment in the relationship, and expectation of eventual reward (See later discussion of 'sunk-costs'). We saw however, that some women went on to experience ambiguous thoughts and emotions when they find themselves living with a 'dry' Dr Jekyll. Consequently counselling psychologists need to exercise caution in *recommending* confrontation, as the potential cost and benefits need to be assessed by the client.

The remaining coping theme from this research, *'self-preservation'*, is distinct as its main focus of effort is the woman herself rather than the drinker. The women's main aim in *'self-preservation'* seemed that of creating either psychological and/or physical distance between themselves and the drinker. In the alcohol domain, *and* as a partner, there are times when

giving-up is adaptive, functional and consistent with *personal* wellbeing. This resonates with Al-Anon's philosophy of 'detachment with love' (Cutland, 1998), and Orford et al.'s (2001) 'withdrawal' strategy, which was associated with greater psychological health. Withdrawal is also consistent with mainstream literature on 'shifting from optimism' as a congruent response to the environment (Sweeny et al., 2006, Sweeny and Shepperd, 2007a+b; Peeters, et al., 1997).

'Un-bracketing' mainstream a priori coping literature draws us back to the benefits of perseverance and engagement, by association with optimism and pessimism. Specifically, embracing a wide range of coping efforts which err towards the active, approach, and problem solving coping strategies, as above, is often associated with optimistic personality orientations (Solberg Nes and Segerstrom, 2006; Suls and Fletcher, 1985). In turn, optimistic future expectations are associated with confidence and tenacity rather than doubt or pessimism (e.g. Scheier and Craver, 2002).

Interestingly, Brennan et al. (1994) found that middle-aged (compared with younger) PPDs endorsed two *contrasting* coping strategies, cognitive-approach strategies (positive-reappraisal) and avoidance-coping (resigned-acceptance); consistent with optimism and pessimism respectively. Similarly, Herzberg et al. (2006) demonstrated an association between middle-age and dynamic flexibility of optimistic and pessimistic concomitants such as coping strategies. Hulson and Russell (1991) also note that older adults are more skilled at dealing with relationship problems. Authors such as Folkman and Moskowitz (2000; 2007), Peeters et al (1997), Sweeny et al. (2006), and Weber, Vollmann and Renner (2007) emphasise appraisal of and responsiveness to the realities of life. Consequently cognitive vigilance and flexibility are highly prized.

Casswell et al. (2011) also acknowledge coping blends in relation to wellbeing with a problem drinker, but refer to ambiguity rather than benefit. Collectively these findings suggest that middle-aged individuals have the potential to maximise their coping efforts by 'straddling' optimistic-pessimistic orientations to coping, which is consistent with a two-dimensional view of optimism and pessimism as independent constructs. It is not possible to make any firm conclusions about the women's levels of optimism or pessimism but many appeared determined, hopeful and tenacious; although less so in Sandra's case (see later).

More broadly, coping with a problem drinker needs be set within the wider 'everydayness' of two people trying to maintain a sense of individual identity within the commitments of a co-joint relationship. Although the stress and coping perspective in Chapter 1 focused on

stressful situations rather than personality antecedents, it acknowledged an important role for 'marital' interactions as mediators of personality characteristics and hence appraisals of stress and wellbeing (Cranford et al., 2011; Karney and Bradbury, 1995) to predict the quality and stability of relationships with problem drinkers. For example, Cranford et al. (2011) considered a diagnosis of 'alcohol use disorder' as an 'enduring vulnerability' which skewed the ratio of 'marital interactions' towards more negative than positive, and reduced 'adaptive processes' such as problem-solving and social support. Karney and Bradbury' (1995: 23) maintain that "any variable [e.g. an 'enduring vulnerability' or personality characteristic] that affects a close relationship can do so only through its influence on ongoing interactions". If we consider the four factors of marital failure (criticism, contempt, defensiveness and stonewalling) identified by Gottman (1994) as 'enduring vulnerabilities' we might predict negative consequences for both interactions and marital satisfaction in relation to living with a problem drinker. Alternatively we might substitute positive personality characteristics that appear associated with martial success and satisfaction to facilitate a functional and happy partnership.

Rosen-Grandon et al. (2004) derived three 'marital' characteristics, love, loyalty, and shared values, which were associated with marital satisfaction. We have seen evidence of love and loyalty being salient for the women, also the fact that none of the men left the relationship and 6/9 in-remission seemed to have stopped drinking out of concern for their wives, indicates shared values. The current model (Figure, 4.1) also included individual differences, which in this research include, personality orientations such as optimism-pessimism, assertiveness, forgiveness, anger, anxiety and emotional tendencies. I argue that the influence of such marital characteristic and individual differences can be 'traced' throughout the women's narratives. Frank for example, seemed motivated into recovery by Fay's intolerance, lack of forgiveness, and pessimism for their future. Colin on the other hand, may have sought to 'reward' Christine's supportive and optimistic stance. Any couples counselling needs to explore the dynamics of the individuals involved and acknowledge different paths to harmonious relationships.

Whilst the synthesis of themes with existing literature (as above) has provided some clarity regarding functional and dysfunction coping efforts, it has perhaps lent more coherence to the women's lived experience than existed in 'reality'. Orford (1998: 29) notes that coping with a problem drinker is not limited to "well-thought-out and articulated strategies, nor to ways of understanding or responding that the [individual] believes to be effective". My synthesis, of necessity, has reduced the 'messy' distress and complexity that appeared to exist in the *'thick of it'*. However, I, like Orford, embrace and respect the women's coping

efforts regardless of whether they were ‘successful’ or otherwise, and almost felt some of the women’s relief as their drinker reached ‘rock-bottom’.

4.7 Superordinate Theme Four: Reaching Rock Bottom

Subtheme: *Experiencing relief and positive emotions*

At this stage in the journey the drinker reached a critical point and either realised that he ‘must’ stop drinking (David-Denise, Frank-Fay, Greg-Gemma, Martin-Mary, Simon-Sandra) or suffered an acute collapse (Colin-Christine - third relapse, Henry-Heather, Oscar-Olivia, Ben-Beverley). In many cases the women appears to have reached their own *‘rock bottom’*, inability to cope, and in some cases brought the drinking problem to a head; notably Sandra’s row about Simon bringing difficult strangers home, and Beverley’s *“near breakdown”*. These women, who had found many and various ways to cope in the *‘thick of it’*, suddenly find the need to cope no longer exists; instead they experience a heady mix of exhaustion and relief.

The only subtheme I identified with *‘rock bottom’* was *‘experiencing relief and positive emotion’.* Being transparent I own to some reservation concerning the title and even the substantive significance of this theme. Firstly, most narratives did involve the women interpreting this location with relief or positive emotions, but not all women made distinct or prolonged contributions in this respect. Have I been guided by the ‘easy’ assumption that *‘rock bottom’ would* be experienced as a wholeheartedly positive development? Certainly, immersion in the data showed a mixed and complex picture, from great relief, to deep reservation, as the women surfaced with ‘dry’ partners However, to have merged this subtheme into the meaning-making evident in *‘navigating new relationships’* (see later) would have masked strong evidence of sharp discontinuity in the women’s lives.

In sum, ‘rock bottom’ was experienced as more significant than a change from ‘wet’ to ‘dry’ partner, it gave the women chance to ‘breathe’ and take stock and heralded the possibility of happier times.

4.7.1 Counselling for Recovery

The tenacity and resilience we saw in the *‘thick of it’* can be compared with Selye’s (1976) seminal conceptualisation of biological responses to stress (General Adaptation Syndrome, GAS), specifically the ‘stage of resistance’. The individual sustains their coping efforts but at

considerable cost to their physiological, and subsequently psychological coping resources. If significant stress continues and/or worsens, as was the case here, coping resources become depleted. Selye's final stage, the 'stage of exhaustion', seems to mirror the couple's experiences of *'rock bottom'*. It is valuable for counselling psychologists to be mindful of the hidden, but nonetheless important physiological implications of prolonged stress. Of note, Lapate, Van Reekum, Schaefer, Greischar, Norris, Bachhuber, Ryff and Davidson (2014) conducted a longitudinal study which examined the impact of marital stress on emotional health in adults (39-84 years), which they associate with psychiatric disorders, particularly major depression. Their results indicated that marital stress is associated with short-lived responses to positive stimuli (pictures in this case) due to changes in activity of the corrugator supercilii (implicated in mediating affective states). Such findings suggest that relationship conflict and distress may blunt emotional experiencing of potentially positive events, and in this case, recovery. The importance of prolonging positive experiences will be discussed in the last superordinate theme.

Returning to situational factors, some women experienced *'rock bottom'* as a time when a number of negative events seemed to merge with their partner's drink problem. For example, a fire in Henry's workshop, Fay, Denise and Mary all had *"issues at work"*, Greg caused accommodation problems, Colin and Oscar occasionally *"went missing",* and all bar Denise and Mary experienced financial difficulties. Holmes and Rahe's (1967) stimulus, situational or 'life events' view of stress would predict higher than average stress scores, which in turn would indicate vulnerability to health problems. This conclusion usefully reminds practitioners of the importance of context, and the cumulative nature of stress when making assessments and formulations.

Whilst not denying the importance of the approaches to stress outlined above, they both effectively mask the rich *dynamic* complexity of lived experience at issue in this study. Dynamic, transactional, process models of stress (e.g. Lazarus and Folkman, 1984; Folkman and Lazarus, 1985; Folkman et al., 1986; Folkman and Moskowitz, 2000, 2007) are most consistent with the experiential focus of this study. These models incorporate personal appraisals of the environment by which events are construed according to individualised mediation. In other words, although nine women seemed to experience *'rock bottom'* as an overwhelming and dramatic shift, narratives reveal significant individual nuances. Consequently we might usefully look towards the contemporary person-centred theorising on post-traumatic *growth* (e.g. Linley and Joseph, 2003; Joseph and Linley 2005; Joseph, 2004; Linley, 2003) to embrace the dynamic individuality of the women's meaning-making.

The women's experience of *'rock bottom'* did not involve a trauma in the more usual sense of confrontation with death and injury, as in major disasters, sexual assault, war experiences and so on. In most cases however, they did witness an acute or severe, relatively violent experience of physiological and psychological breakdown. This caused both partners extreme shock and distress. Afterwards, most of the women appeared to be "actively engaged in struggles to find new meaning in their lives, and … [felt] that they have learnt important lessons from their experiences" (Joseph, 2004: 101). The focus on growth, stands in contrast with the predominately restorative focus of (N.I.C.E. recommended) CBT approaches to Post-Traumatic Stress Disorder (PTSD) (e.g. Foa and Rothbaum, 1998; Grey, 2008; Padesky, 2007), which employ exposure based techniques leading to re-experiencing.

Joseph and Linley's approach draws upon the work of social psychologist Janoff-Bulman (1989, 1992, 1999) who believes that the experience of trauma has 'shattering effect' on peoples' assumptions of the world as a just and fair place, where people get what they deserve. The experience of trauma shatters this core belief in justice by showing "with stark clarity that the world is not just" (Joseph, 2004: 106). Person-centred therapy works towards accurate symbolisation in awareness of experience, which is necessary for reintegration of self and experience to take place. At least a moderate 'grounding' in reality seems 'safe' and desirable, and might lessen disappointment if any of the nine 'dry' partners were to return to drink. It is also considered vital to progress at the client's pace (Tolan, 2003).

4.8 Superordinate Theme Five: Resurfacing Reservedly

Subthemes: *considering sunk cost; revisiting responsibility; gaining strength through adversity.*

After the initial relief of recognition that their partners have now stopped drinking most of the women enter a period of re-evaluating their situation, and gaining strength and confidence in a very new reality; apart from Christine who has experienced this phase three times previously. The three subthemes *considering sunk costs; revisiting responsibility; gaining strength through adversity* reflect this contemplative stage of the journey. The women are trying to understand and navigate 'where they are' now. This process involves conflicting and ambiguous thoughts, which were interpreted as understandable and 'normal', although potentially anxiety provoking. However, there was also a sense of the women having gained an opportunity to take stock and 'dare to believe' that a better future is possible.

The distinct differences in the women's 'lived experience' here signalled significantly changed stances, which they take with them into their *'new relationships'*. The major difference is the vastly reduced necessity to cope with the worst excesses of their partner's drink problem. Specifically, there is less need to confront, control, monitor and worry; although these characteristics still appear to a greater or lesser extent, on an individual, rather than a collective basis.

This is consistent with Barker's (2013) belief that we would do well to 're-write the rules of our relationship', to suit ourselves. For example, some of the women resurfaced just after their own particular 'rock bottom' and realised that they did not have to, or moreover were not prepared to, 'be mother' any more.

Having survived 'rock bottom', both partners have an opportunity to navigate new ways of being for the benefit of themselves and the relationship. For example, Olivia seems particularly determined not to return to the roles of *joint* social conscience or being Oscar's 'mother'. This offers the chance for her to live her own life more fully and enjoy a mutually negotiated shared future. This impetus for *"simple pleasures"* and *"freedom"* might facilitate a more 'open' environment where Oscar can give *sober* free expression to parts of himself without fearing judgement (Shinebourne and Smith, 2009).

4.8.1 Counselling for Living in the 'Here and Now'

All 'dry' themes were notable in that they had lost much of their retrospective feel; the women seemed with me in the 'here and now'. One of the key aspects of this 'here and now' thinking concerned their evaluations of which sunk costs needed to be 'written-off' and what future investments should or could be made.

Researchers seem to agree that only 'here and now' thinking allows 'logical' and self-protecting investment decisions to be made. For example, Staw (1981) proposes that one of the reasons that people maintain investments is a reluctance to deviate from (a priori) stereotypes that accentuate the benefits of steadfast behavioural consistency over time. Similarly, Strough et al. (2011) recognise the potentially burdensome nature of past costs, whilst Wong and Kwong (2007) believe 'sunk cost bias' occurs due to anticipated (future) regret, given that the person concerned was responsible for initiating the previous decision.

Accordingly, Hafenbrack et al. (2013) advocate mindfulness as a means of cultivating awareness of the present moment, either as psychophysiological state (e.g. Kabat-Zinn,

Massion, Kristeller, Person, Fletcher, Pbert and Santorelli, 1992) or trait (Brown and Ryan, 2003), to reduce our tendencies towards a 'sunk cost bias'. Such mindfulness, reduces the extent to which current experiencing is negatively influenced by the past, or drawn towards the pressure of future expectations.

The women in this research now have the 'luxury', for the first time in quite a while, to *really* reflect on their future. They are more able to contemplate 'appropriate' responsibility, future investments, and also what they are not prepared to do any longer. Of note, Olivia makes scant reference to the present as she looks almost exclusively to the future. Olivia's narratives revealed her strong preferences to compartmentalise home and work as an important aspect of her *self-preservation;* compartmentalising past distress from her future goals might serve a similar function. This curtailing of thoughts for the present arguably limits the congruent, 'here and now' experiencing of reality as advocated by Rogers (1951; 1957; 1961).

If similarly middle-aged individuals they were to present as our clients we might usefully note the following additional empirical evidence: People report greater happiness when they focus on the present moment than when they think about the past or future (Killingsworth and Gilbert, 2010); negative emotions exacerbate the 'sunk cost bias' (Moon, Hollenbeck and Maue, 2003); Sutton (2013a) reports on Bruine de Bruine's (2013) rare investigation of aging and decision making and concludes that older adults are 'better' at making 'life' decisions which preserve or enhance their wellbeing (as long as they are not too cognitively demanding). She believes it is not logical to base decisions on prior cost, which are always irrecoverable and coping skill mediates as older adults engage in more positive reappraisal; which is consistent with Brennan et al, (1994) in their research with middle-aged PPDs. This last conclusion was further explored by Strough (2013) who suggests ageing limits our future time perspective and older people tend to ruminate less in the face of obstacles. In sum, therapists need to facilitate flexible, congruent, 'here and now' thinking and feeling.

Somewhat linked to the issue of 'sunk costs' is that of prolonging *uncertainty*, which may enhance the women's sense of gaining strength at this point in their journey. A number of disparate but illuminating references attest to the potential virtues of uncertainty as follows: Bar-Anan et al. (2009) and Wilson et al. (2005) conclude that the 'pleasures' of uncertainty prolong positive moods by intensifying affective reactions. Wilson et al. (2005) also note the irony of these findings as human beings spend much of their lives trying to 'eradicate uncertainty' and transform the unknown to the known; hence they use the term 'pleasure paradox'. Similarly Dryden (2011) advocates 'tolerating' uncertainty, almost like tolerating

anxiety, and Barker (2013) and Ryle (1979) both believe that embracing uncertainty alongside other qualities such as flexibility enhances relationship satisfaction.

> The emergence of a more developed consciousness, of the capacity tolerate more uncertainty, of the acceptance of a more individual responsibility, and the letting-go of a comfort-adherence to provided solutions, and of coercive dependency upon the other, represent real human gains (Ryle, 1979: 149).

Finally I would argue for a 'here and now' mind frame to include the retaining and valuing of some pessimism from the previous times of adversity. Valuing pessimism resonates with Thompson's (2004) thought-provoking reappraisal of the psychoanalytic conception of suffering which emphasises the benefit of accepting some unhappiness. As Freud considered himself a realist he believed the analyst's role was to confront patients with harsh realities they prefer to avoid, "promis[ing them] nothing except to know where [they] stand" (ibid: 149). Freud (Breuer and Freud, 1955) believed people should be content with "common *un*happiness" as happiness may be desired by (particularly neurotic) clients, but cannot be given by therapists. Similarly, Held (2002) notes, "our [American] culture-wide tolerance for unhappiness has so diminished that we have become less able to accept feeling bad sometimes as healthy" (ibid: 980). These notions are consistent with the philosophies of existential psychotherapists such as Irvin Yalom (2006, 2001, 1989, 1980).

4.9 Superordinate Theme Six: Navigating New Relationships

Subthemes: *Positive future expectations; one day at a time; living together apart; living with drink as the elephant in the room*.

In the later stages of reading, analysing, and interpreting the women's narratives a subtle but deeply significant superordinate theme seemed evident – *'Navigating New Relationships'*. Essentially these 'new' relationships evolve in three distinct directions: those infused with *'positive future expectations'*; more cautious and ambiguous, *'one day at a time'* and Sandra and Ruby's which are characterised by lack of joint involvement, *'living together apart'*. At this point on the couples' journey, apart from the nine couples being in-remission, there is far less common experience.

White (2007) reviews contemporary thinking on recovery and concludes that as well as 'recovery' being a difficult term to define it should be considered a complex and long-term process. Similarly, Irving's (2011) analysis of 'narratives of recovery' (from alcohol dependence) informed him that there is more to identity reconstruction in-recovery than just

giving up the drink. The women were not specifically asked for their beliefs or expectations concerning 'recovery', but the three subthemes evidenced a variety of stances. These ranged from Christine who spoke as if drink would never 'enter the equation' again (despite Colin's previous relapses), to a much more tentative *"we'll see how it goes"* from Gemma and Mary, to Sandra who seemed to envisage a 'permanent' recovery, but with a strong sense of gloom, almost despair.

4.9.1 Counselling for Independent but Partnered Living

Given that this is the last superordinate theme I will base my practice related discussions on some brief reflections of the end of the women's journey.

Despite expressions of relief and optimism (genuine, 'illusory' or 'intentionally' constructed) I felt a deep sense of ambiguity, fragility, and loss in the 'dry' themes. Christine's optimism and banishment of "stinking thinking' (Al-Anon's pessimism) for example, felt both 'forced' and potentially 'dangerous'. She had experienced three previous relapses with Colin, each being more acute than the previous, but seemed to deny any possibility that this could happen again. Beverley seemed sad, tentative and somehow damaged by her shattered faith in fair treatment – wanting to believe in Ben's commitment to giving up drink and drugs, but hardly daring to. Mary seemed to feel Martin's loss of his previously enjoyed drinking culture, and his sadness as he withdrew from his friends who continued to drink. Sandra seemed the saddest of all. She felt lonely, abandoned, side-lined and almost totally without enthusiasm for the future. Collectively there was a sense of unhappiness or dissatisfaction, but without due cause – they had what they wanted, the return of Dr Jekyll – but many seemed somewhat disappointed, like an anti-climax. All of these reflections raise ontological issues around the stability or changeability of the self.

I will now provide a number of possible directions which counselling psychologists might find helpful to consider:

Essentially the nine women with currently 'dry' partners have an opportunity to *'navigate new relationships'* on a much more equal footing and with a resolve to try and avoid the worst excesses of a drink problem in the future. In turn, this involves a degree of congruence to reality such that they can embrace and enjoy the 'good' times, even if this involves *"simple pleasures"* like Olivia's joint shopping trips; as Ussher (1998: 161) says, "no change is too small to be worth implementing" to 'break the cycle' of relationship unhappiness. However, congruence and flexible functioning also involves accepting some negative thoughts and

pessimism (as mentioned previously) and being cognisant of embracing excessive optimism, particularly when it is not genuinely experienced (Held, 2002, 2004). Sweeny et al. (2006) proposed that rarely acknowledged 'shifts' from optimism serve goals of preparedness which equates to readiness to deal with setbacks and to take advantage of opportunities. These authors recognise the need for individuals to be responsive to changes in their lives and appraisals of their situation in order to cope effectively. Accordingly people need to be responsive to new information (internal and external) and to the possibility of undesired outcomes.

However, for some individuals indulging pessimistic thoughts can however signal a *personal* failure to remain optimistic, and for some may represent a conflict with their religious and personal beliefs. Religious faith was particularly important to Christine and Ruby. It further sanctioned their endorsement of optimism and resistance to negativity which amount to cultural imperatives. Orford et al (2001) suggested that religious activity played an important role in maintaining traditional, collectivist (versus individualist) loyalties and duties. These attitudes can involve some self-sacrifice and tolerant-inactive coping strategies, which are viewed as potentially detrimental to health. Given that this potential 'pressure' towards optimism (Held, 2002; 2004) was not restricted to religious participants, it can be argued that many participants experienced pressure towards inhibiting their congruent expression of anxieties and fears. Therapeutic intervention which involves 'giving permission' to express negative thoughts, needs to acknowledge these potential obstacles to congruent experiencing. Similarly, for some women, facing their realities may affect delicate balances involved in remaining with their problem drinker.

I am currently exploring Dialectical Behaviour Therapy (DBT) in my private practice as I value its 'blend' of person-centred attitude alongside CBT's more directive approach to specific aspects of content and potentially dysfunctional beliefs. In essence DBT (e.g. Jackson and Linehan, 2010) aims to hold a dialogic balance between respecting the client's current positions, and being vigilant to more proactive opportunities to facilitate change. DBT also seems consistent with the therapeutic protocols developed by Copello and colleagues (1996; 1998b) for substance misuse problems and is viewed positively by Roberts (2015), in a review of interventions for alcohol misuse; specifically the work of Dimeff and Lineham (2008). These authors suggest sharing the problem with someone who has specialist knowledge and no personal involvement with the drinking problem such that they feel heard and understood. This gives clients 'permission' to express fears, anxieties and doubts in a safe non-judgemental environment. This also allows the therapist to provide reassurance, normalise negative experiences by reflecting or 'negotiating' different perspectives, and

bringing the problem into open. Such interventions are consistent with bringing a sense of relief, a more positive attitude, confronting the problem, gaining accurate information and increased confidence.

4.10 Ruby Alone

The key to Ruby's ability to remain with Ray is her increasing involvement in independent pursuits; autonomy and a sense of personal agency infused her interviews. This 'new' life has been largely fostered and supported by her commitment to working within the Al-Anon ethos. I am considering writing an IPA case study for Ruby, which would be entitled, 'Al-Anon assisted renaissance'.

However, combining agency with Ruby's acceptance of *Ray's* responsibility for his drink problem limits the opportunities for involving him in her non-drink related social networks. Copello et al. (2002) believe that wider social support networks, beyond the couple, are conducive to changing a drinker's behaviour and likely to provide occasions to "positively reinforce sobriety" (Kahler et al., 2003) as a positive coping strategy. Ruby described occasions where she would invite Ray to be involved in a joint life, like becoming more active in the local community or joining her on trips to see the children; he side-tracks most of these offers. She approaches these disappointments with a pragmatic attitude, she would be delighted if he accompanied her, but quietly goes ahead alone if he declines.

4.10.1 Counselling for Continuing to Live with a Problem Drinker

It is important to recognise that a client who presents themselves as being in the *'thick of it'* of a partner's drink problem could potentially remain in this place indefinitely. If so, they would almost certainly face Ruby's dilemma – do they stay and try to make the best of it (e.g. Edwards and Steinglass, 1995), or leave in the hope of something 'better'? As therapists, we need to accept the client's decision, and not rule out the possibility that our therapeutic efforts might be best employed at effecting the least distressing possible ending (Street, 1991). If a PPD decides to stay, it is worth remembering that Sobell et al. (1993) noted that the majority of problem drinkers stopped drinking unaided. This might allow the therapist to explore the individual's balance of concerns for themselves in relation to their partner, and facilitate 'redefinition rather than rediscovery' of their selves (Bennum, 1991).

Organisations like Al-Anon also provided valuable social support which allowed Ruby and Christine to feel less alone and stigmatised. In sharp contrast, Fay expressed distaste,

almost revulsion at being expected to reveal her problems to others. She believed this would signal *her* blame and responsibility for choosing an alcoholic partner, which is consistent with her pessimistic stance on occasions. Fay's reluctance to involve others, including counsellors reminds us of the growing realisation that there are complex and multiple pathways towards resilience (e.g. Bonanno, 2004).

4.11 The Role and Value of Counselling Psychology for Partners of Problem Drinkers

The three therapeutic perspectives underpinning the current research (individual differences; stress and coping, and cultural and community) amalgamated alcohol-specific approaches and mainstream psychological theory, which might usefully support intervention initiatives in a range of settings, clinical complexities, and counselling approaches. Notably, Orford (1984) recommended a multifaceted approach and similarly, NICE (2010) advocates a 'suite of interventions' to provide the most benefit to those living with a drink problem in their midst. Further, Roberts (2015: 5) states "it is clear that no one psychological approach [for alcohol misuse problems] is suited to all individuals and the choice of the most suited intervention for an individual is highly complex". This choice and complexity, according to Roberts (2015), might valuably include so-called third wave psychotherapies such as mindfulness (e.g. Zgierska, Robago, Chawla, Kushar, Koehler, and Marlatt, 2009), Acceptance and Commitment Therapy (ACT), and Dialectical Behaviour Therapy (DBT, e.g. Dimeff and Lineham, 2008). Of note, the current researcher makes reference to the potential value of these more contemporary therapies in conjunction with those that are already well established. This guidance seems valuable primarily for the individual counselling psychologist in whichever setting they may encounter a PPD. It is however important to consider a wider context for intervention with a group who appear vulnerable, under-represented in research, and under-resourced in both national and local provision arrangements.

The Department of Health (2002) recommended that substance misuse intervention be provided within their Models of Care for Alcohol Misuse framework (MoCAM, actioned for alcohol misuse in 2007), which is divided into four Tiers. Counselling psychologists can work within in all four MoCAM tiers, from involvement with non-specialist services such as social services and primary care (Tier 1), through low threshold (Tier 2), community based services (Tier 3) to in-patient and residential services (Tier 4). These Tiers are somewhat consistent with NICE recommendations that psychosocial services be classified as either low or high intensity. In other words, counselling psychologists need to be flexible and adapt their knowledge and skills to be accessible to a range of organisations and service users.

Unfortunately a number of publications (e.g. Alcohol Concern, 2010; Roberts, 2015) have highlighted significant shortfalls between Government targets for intervention for alcohol problems and so-called 'real-world' services at local level (Roberts, 2015). This shortfall is exacerbated by lack of appropriate and accurate data and recent funding cuts (Roberts, 2015), and the fact that most of the interventions prioritise the problem drinker and not their partner. Despite this less than ideal provision I offer the following recommendations which have been 'distilled' from the synthesised findings from the current research.

1. Working with PPDs whilst they remain with their partner involves balancing the needs of the *individual* with their status as one of a *couple*. Counselling psychologists need to exercise caution in cases where *they* believe a particular client may benefit from staying or leaving; this needs to be checked with their empathy and understanding of the client's 'frames of reference'.
2. Increasing dissimilarity (specifically in drinking behaviour and/or aspects of self) signals great worry, conflict, discontent, and partnership dissatisfaction. It seems advisable to consider ways in which the individuals concerned gain and maintain intrinsic motivation and 'happiness'; this may involve moderate positive illusion, embracing some uncertainty, and/or developing their own 'rules' of their relationship.
3. PPDs seem to benefit from embracing rich, dynamic, multi-faceted coping strategies, even if some of these are contradictory and/or counterproductive. We must exercise caution re recommending strategies (like confrontation) or 'stripping' what we consider to be unhelpful strategies (like excessively *'being mother'*), as they may be intimately linked to that individual's strongly held beliefs, religious convictions or personal resilience. Specifically, note the ambiguity regarding confrontation .v. withdraw and strategies aimed at the problem drinker .v. those aimed at *'self-preservation'*.
4. Recognise that although *'rock-bottom'* represents an important discontinuity in problem drinking it is merely the start of a seemingly long-term and substantive period of (self) change and *'navigating new relationships'*; neither the problem drinker nor their partner can ever be the same person they were before. This 'location' in the life of PPDs is the least researched of all those pertinent to PPDs, but I interpreted aspects of ambiguity and fragility that seemed barely acknowledged by the participants themselves. This involved their uncertainty about whether drink was *really* out of their lives, whether *they* could continue to drink, and more fundamentally, were they now living with their familiar 'Dr Jekyll' or somebody they did not quite recognise? Sensitive, empathetic, non-judgemental exploration by

counselling psychologists is indicated so that PPDs are empowered to make their own decisions.

5. Further to the point above, the 'dry' phase for most of the nine participants seemed to be a time of reflection and *'taking stock'*. Most considered their *'sunk costs'*, and *'revisited their responsibility'* for monitoring their problem drinker. Some seemed determined to use their adverse experiences as a platform for growth and 'moving on'. Sandra appeared disillusioned and mildly depressed, as she found herself *'living together apart'* with Simon. My suggestion for this 'location' is to focus intervention in the 'here and now' as this seems to be the most conducive time frame in which to make 'logical' self and relationship enhancing decisions.

The above recommendations are consistent with those few researchers who have also developed practice guidance for those working with PPDs; notably those working from a 'stress and coping perspective' (e.g. Copello et al., 2010; Howells and Orford, 2006; Orford et al, 2010a+b; Velleman et al., 2011). Much of the more recent intervention work, notably built on the work of Orford and colleagues (e.g. Orford et al., 1998), has provided broad parameters which might usefully be embraced by counselling psychologists. For example, Vellemen et al.'s (2011) review of the 5-Step Intervention (Copello et al., 2010) advocates: listening; providing information; looking at ways of coping (current) and discussing alternatives; exploring and discussing support; summarising and assessing whether further work needed – if so referring on. Similarly, Orford et al.'s (2010b) review of qualitative findings from PPDs highlighted the desirability of individualised support and the provision of accurate information from professionals. PPDs especially valued practical coping support and feeling 'backed-up'. They also valued intervention from people who appeared positive about the problem drinker (i.e. interacted positively with the drinker, if appropriate, or saw him/her as someone who deserved to be helped and supported, and who potentially could change). These points resonate with the current findings, particularly with participants such as Fay, Olivia and Gemma who did not want to be told that they should *"just leave"* their partner, although all participants seemed keen to tell me that their partners were 'not all bad'. Orford et al. (2010), like the current research, presented a picture of the multi-layered nature of stress and distress, which precipitated very mixed feelings and hence suggested sensitive and respectful intervention.

4.12 Epistemological and Quality Considerations: Strengths and Limitations of IPA

Eatough and Smith (2013) view IPA as a qualitative method which makes important connections back to the primary importance of subjectivity in personal accounts. They, like

me, value IPA's embracing of the early work of William James and Gordon Allport, which represents a return to a way of working that is firmly grounded in psychology. IPA also allowed a search for common patterns *and* individual differences thus reducing the dangers of promoting a psychology of "one size fits all" (Molden and Dweck, 2006) which obscures how real people actually function. Similarly, Ponterotto, Kuriakose and Granovskaya (2013) believe that qualitative methodologies add human reference to operational definitions of constructs, which are often predicted solely by researchers and offer limited response options.

Specifically, my analysis provided rich, vibrant, and very 'human' insight into the challenges the women faced with their problem drinker. Their accounts were embedded in rich social and cultural contexts and the significant life events and experiences were considered "ostensibly truthful [as in] not purporting to be works of fiction" (Velleman et al. 1998a: 11) and provided further 'scaffolding' for the meaning-making. Velleman et al. (1998b) caution researchers against getting side-tracked into worrying about the truth of a recollection, but rather concentrate on its current value to the individual. These assumptions are again consistent with IPA, a critical realist stance, and Allport's (1937 [1961]: 1946) views of 'idiographic intent'. These epistemological underpinnings assumed the women's contact with an independent reality from which to construe meaning and engage in thoughtful, intentional, self-regulatory activity (e.g. Bhaskar, 1979, 1986; Harré, 1998, 2004; Robson, 2011; Smith et al. 1995, Willig, 2001; 2012; 2013).

I believe that embedding the themes in this research within a predominantly retrospective journey (like Gubi and Marsden-Hughes, 2013 and Flowers and Buston, 2001) lent coherence and credibility to the dynamic, multifaceted process that unfolds whilst living with a problem drinker. Personal reflexivity of key inter-subjective experiences arguably lent impetus to viewing the women's voices as carefully distilled and credible, and ultimately 'real'. I valued and enjoyed the opportunity to conceptualise human *being* (ontology) as a self-interpreting, circular, hermeneutic process. This stance allows the 'messy and chaotic' aspects of my participants 'lived experience' as much credence as the more controlled and conscious aspects. Much of my earlier training and experience, predominantly within a quantitative paradigm, had instilled a sense of needing to tie-up ends, remove 'outliers', and present a clear unambiguous result. My 'adventure' (Willig, 2001) into IPA has 'cured' me.

In terms of the analytical procedures and process: the transcription of data was thorough, verbatim and repeatedly checked for accuracy; all transcripts were fully analysed; resultant themes were worked and reworked with reference to the participants' perspectives, a priori

formulations, supervisory discussions and four independent ex-partners of problem drinkers (who volunteered) were 'bracketed' and then 'unbracketed'; analyses involved 'empathetic' (manifest) and 'suspicious' (latent) interpretation (Willig, 2012); and exemplars in the Appendices attempt to show openly and honestly how decisions were made. I also worked with the transcripts with an accepting attitude towards contradictions and tensions within and across the data, and came to appreciate the importance of retaining accounts that depart from the dominant themes. In addition, care was taken to ensure that language and concept use was consistent with the philosophical underpinnings of this research (see Chapter Two).

Conscious efforts were made throughout to allow the *data* to act as the first 'driver', which involved 'bracketing' both a priori literature and initially my own subjectivity (whilst remaining aware of my perspectives and noting these in my journals). This issue was most apparent in relation to the coping themes, given the vast wealth of mainstream and alcohol-specific literature and wide variety of descriptors. The resultant themes appear to reflect the data without denying the value of existing formulations.

One of the aims for this research was for it to hold relevant to a range of therapeutic approaches. I believe that this aim has been fulfilled in that the 'double hermeneutic' allowed my subjectivity and then 'unbracketed' knowledge of counselling psychology to inform the commentaries, synthesis and discussions. I was also aware that my expertise in person-centred and CBT approaches came to the fore. Although mindful of psychoanalytic 'pulls' I felt them more appropriate for a case study IPA (of which there is a growing number, e.g. Oakland et al., 2014; Robson, 2002; Shinebourne and Smith, 2009), particularly in the case of Ruby. Similarly, Holloway and Jefferson (2005) emphasise the effects of unconscious conflict on choice and agency, in comparison to my largely CBT and P-C approaches, with fascinating commentary and interpretation of 'Vince' and his employment dilemmas. Similarly, Frost, Nolas, Brooks-Gordon, Esin, Holt, Mehdizadeh and Shineborne (2010) report on pluralism in qualitative research and provide rare insight into alternative qualitative methods using the same data; this would prove interesting for this research.

There were times when I felt myself drawn into the drinker's world, rather like a 'triple hermeneutic', and would have valued following up some of the 'leads' to his perspective. Following Weed's (2005) arguments for greater synthesis of published research *findings* we might usefully refer to IPA insight of 'Alison' (Shineborne and Smith, 2009), a recovering alcoholic, to provide a 'mirror' for the PPD's in this research. Alison evocatively suggests that alcohol allowed under-expressed or excessively socially inhibited parts of herself the freedom to flourish; maybe my women's drinkers increasingly refer to a similar part of their

selves[15]. Early seminal discussions of the self as a multifaceted entity were presented by William James in 1890. They have provided a platform for many subsequent formulations including those of AA and Al-Anon who view the alcoholics' journey as one of self-discovery and self-integration.

There are important issues of 'reliability' and 'validity' however that still need to be acknowledged. Most notably human memory is fallible and subject to personal and cultural biases. Although dated, Bartlett's (1932) book *Remembering* remains one of the most fascinating and ecologically valid insights into the selective, reconstructive, interpretive nature of memories. Bartlett's work, and the research that it inspired lead psychology to explore attributional biases, the differential salience of life events, the role of intensity of emotional and motivational experience, and the influence of significant others in the memory process. All these processes hold relevance within this research and will have helped to shape the findings and their analyses. Many of the biases and illusions seem heavily culturally driven and lead to the kind of distortions and omissions that Bartlett (1932) observed.

Despite following the guidance and examples of IPA (see Chapter Two), nothing can totally prepare researchers for all the ambiguities and inconsistencies they inevitably face. Most notably I attempted to check for sufficient connection with the complexity and counter-evidence, as advised by Joffe and Yardley (2004), or 'anomalies' (Braun and Clark, 2006). In this way I hope I have limited the degree to which my analyses were open to subjective *bias* (rather than acting as a 'conduit'), which can generate writing which gravitates to the researcher's personal assumptions.

I am however, conscious of not having explored the emotional 'ingredients' of the women's lived experience as deeply as I might. This is partly due to IPA's primary concerns with cognition and discourse, but partly due to the inherently 'illusive' nature of emotional experience; as Butt (1999: 137) points out, "it is of course impossible to say what we really feel". Butt (1999) provides valuable discussion as to the nature and origins of our emotions and argues that both realist and constructionist approaches (both embraced by this IPA analysis, with a 'soft' caveat on constructionism) misrepresent our emotional experience. He favours an 'existential-phenomenological view' to interpretation, which "recognises the power

[15] Seligman and Kirmuget (2008) go further and refer to dissociative states accessed by drugs alcohol and music in which individuals suspend their normal self with its accompanying social constraints and enables them, therefore, to express novel, even normally forbidden, desires, feelings and behaviours that they experience and attribute to some agency other than the self.

of constructionist critique while preserving the intentionality of the 'lived experience' of emotions" (Butt, 1999: 129). In this way we might usefully capitalise on the scope of IPA to allow theoretical rather than empirical generalisation (Wagstaff et al., 2014) to further draw together 'emotional threads' from this research. Folkman and Lazarus (1985) for example, differentiate between threat and challenge, anticipatory and outcome emotions, a conceptualisation which might valuably lend itself to an 'overlay' of intentionality. In this way, we might help clients to consider and/or re-consider which 'directions' they would choose for their emotional life. Such discussion might benefit Sandra most of all as she appears passively 'trapped' within a mind-set of increasing age and inability to feel joy in the present, or to anticipate excitement for the future. This resonates with recent work by Västfäll (2013, reported by Sutton, 2013b) which suggests that older adults are more able to reduce the intensity of regret (certainly for minor everyday events) by exercising greater emotional selectivity, using their greater life experience, and by keeping an open-ended future time perspective.

In sum, it is acknowledged that the interpretations and arguments contained within these analyses are construed within my academic scholarship and inter-subjectivity with my participants. I have, however, aimed to make these processes clear and transparent.

4.13 Sampling Considerations

All participants (bar Ruby) lived with a partner in-recovery which I believe 'steered' the analysis towards looking back with 'rose-tinted spectacles'. It would have been valuable to have interviewed more women like Ruby who had spent over 40 years with her problem drinker without remission. The richness and depth of Ruby's interview however, allowed many potentially significant comparisons to be made.

All the participants were middle-aged so as to explore an under-represented cohort for whom empirical evidence and theoretical speculation suggest certain coping advantages such as range and diversity of strategies (e.g. Brennan et al., 1994; Herzberg et al., 2006, Robinson and Stell, 2013). A comparison with younger or even older participants would shed further light on age as a mediator of navigating a relationship with a problem drinker.

The eventual sample consisted entirely of women despite strenuous efforts to achieve a gender balance. Whilst this is consistent with the statistics on higher incidence of male drinking problems, it may reflect greater reluctance for men to volunteer for research which causes them to feel 'odd', embarrassed, or unduly stigmatised in relation to their peers.

Either way the absence of male partners of problem drinkers may have 'missed' valuable gender differences. In particular it would have interesting to see the differences that might have resulted with the theme *'being mother'*; would a theme *'being father'* have been identified?

There were also a number of times when an IPA analysis (or at least a qualitative analysis) of the problem drinker (e.g. Gubi and Marden-Hughes, 2013; Shinebourne and Smith, 2009) would have enhanced my ability to interpret the PPD's lived experience. Further, the drinkers were not assessed as belonging to particular subtypes (such as anti-social or not) as suggested by Floyd et al. (2006). Although Heather, Mary and (less so) Gemma's partners exhibited a range of domestic abuse, in comparison with the remaining seven it was not possible to derive strong common themes in this respect.

The sample comprised couples who were still living with their first sole partner, and those who had lived with previous partners. It might be valuable to provide more reflection on possible comparisons and contrasts in this respect or to consider this as a main focus in future research.

Finally all couples were heterosexual so it is not possible to make evidenced comment on potential similarities and differences with GLBT couples. Referring to Flowers and Buston's (2001) IPA analyses of gay men's coming out, we might infer that their experience would include greater shame, distress and contradictory thought processes given the 'powerful societal messages' their participants made reference to.

4.14 Ethical Issues in Collaborative Research

Interviewing the participants about such potentially distressing, and in some cases previously undisclosed experiences, required sensitivity, respect, and care. The tone of the interviews was serious yet warm and all participants provided rich and often intimate material. There were occasions of upset and distress, but these were managed within the interviews, and no one requested counselling. I was also conscious that our interviews were for research purposes not counselling, so I restricted the use of my 'inner voice' to informing my analyses and discussions and not providing therapeutic comment. Similarly, I was committed to the ethical ideal of not making explicit recommendations for change to the participants. This was particularly important in respect of whether the participant was erring towards leaving their partner. Giving advice or endorsing particular perspectives could be construed as

disrespectful and judgemental, both to these women's coping choices, and their decisions to remain with a problem drinker.

In addition to safeguarding the wellbeing of my participants, I believe that this research provided benefits to both participants and researcher. The participants had the opportunity to talk about their experiences. I as the researcher gained insight into these women's lives which I believe will be of benefit to my client work, and counselling psychology more generally. Further, I believe I have gained much valuable learning through my experiences of using IPA.

A consideration of ethical issues is also involved in reporting and potentially publishing this research without explicit consent. For example, my women revealed very intimate details of their private relationships, including occasions of infidelity, domestic abuse, and in one case their partner's investigations of misconduct at work. I accepted the responsibility to either report 'delicate' themes sensitively and non-judgementally if they appeared relevant to the research question, or omit them. I was mindful of the research experiences of Ellis (Ellis 1986; 2001, 2007) who admitted her mistake in effectively abusing the trust of her participants who felt violated by her published disclosures. Further, I felt a responsibility to safeguard the dignity of the problem drinkers who, unlike the women, had not given their informed consent.

A further ethical consideration concerns one of my participants whose story and demeanour left me rather troubled. Reading Bott (2010) I realised that she had become 'other' and somewhat 'disliked'. Sollund's (2008) re-evaluation of 'Yusef' however, gave me the humility and courage to consider alternative explanations for this participant's self-aggrandisement and highly intimate disclosures. I now wonder whether these stemmed from her deep personal insecurities and a need to be valued - It felt like bringing her back into the fold.

4.15 Further Research

As noted above male partners of female problem drinkers warrant greater investigation as they appear even more under-represented and potentially more vulnerable than female PPDs. Would a male partner's path generate similar themes of distress and burdensome responsibility? Indications from studies such as Orford et al (2001) suggest, from a small subset of male partners, that males find it easier to withdraw, perhaps due to differing cultural expectations. However a more contemporary analysis of coping by Philpott and Christie (2008), using Orford's (1996) Coping Questionnaire, reported male partners used

'withdrawal' coping least frequently and 'engaged' coping behaviours most frequently; consistent with the findings from this research.

Another consequence of interviewing females in this research is that it was limited to exploring non-concordant relationships where the male was always the problem drinker. Gubi and Marsden-Hughes (2013) provide a rare IPA analysis of both male and female partners/drinkers, but their research encompassed some important differences which make close comparisons difficult. For example, the drinkers were assessed on diagnostic criteria for alcohol dependence (DSM-IV and ICD 10) and were already well into a period of long-term recovery. Consequently the findings from this current study would benefit from a 'parallel' study of male partners.

Having gained some insight from Beverley, it might be useful to compare experiences of partners of those with a drugs problem, given the different social norms, taboos, and legal and cultural history; some of which were discussed by Orford et al. (2001). Beverley appeared the most traumatised by Ben's alcohol *and* drug use. It seemed to shatter her assumptions regarding him as a partner, and more widely in terms of drug taking as a social problem. On the positive side Beverley's responses might benefit from more individual interpretation in relation to a loss of naivety which gradually gave way to greater congruence and strength for the future.

Finally, this research has really enhanced my knowledge and interest in the dynamics involved in maintaining close relationships, both in periods of 'normality' and adversity. I believe that I have discussed a number of key mediators of relationship harmony and disharmony (e.g. flexibility, mutual responsiveness and open communication) but many questions are left unanswered. For example, are there particular stances or personal qualities that are more suited to some phases of experience with a problem drinker than others? Confrontation for example seems well suited to encouraging a problem drinker into therapy, but may be too unsettling for the 'dry' phases where support and acceptance are indicated. Gaining insight into such issues would benefit counselling psychologists by allowing them to discuss functional and potentially dysfunctional modes of communication. As Barker (2013: 2) says, "people are generally poorly educated about communicating with partners" and this may 'cost' those individuals a potentially valuable relationship.

4.16 Conclusion

This research has provided much insight into the 'lived experience' of PPD's, and through them we know something of their partners and their relationships. Specifically, this study explored meanings and construals for partners of problem drinkers in a way that has revealed both common adversity and striking individuality. The overarching theme, *drinker's path as partner's adversity and challenge'* acted as a 'yardstick' by which to assess the changing realities and demands within these women's lives. The inclusion of both *'adversity'* and *'challenge'* allowed and respected the 'positive'-'negative' balance and ambiguity that exist in 'normal' lives; including those with a problem drinker. Throughout the milestones along the journey a prevalent strand of interpretation was a desire for life with an equal-status, non-dependent *partner*.

The above ambiguity and complexity was most apparent in the coping themes in the *'thick of it',* where some coping attempts were 'successful', 'unsuccessful', seemingly effortless, exhausting, and often a 'chaotic' mix. I suggest that this multi-faceted and potentially contradictory coping effort be regarded in the context of the women as relatively skilled 'readers' and navigators of their relationships; that is to say 'normal' responses to a difficult reality. Steinglass (1981) also recognised the responsiveness of coping skills of families of problem drinkers. They were able to distance themselves in the stable 'wet' stages (here the *'thick of it'*), and capitalise on the stable 'good' ('dry') times. However, like Steinglass, this research acknowledges that the everyday lived experience is far more complex than just 'wet' and 'dry'; each period embraces 'peaks' and 'troughs' and significant individuality. As such counselling psychologists need to present a normalising and non-judgemental stance and attempt to understand the dynamics of the individuals and/or couples involved.

Traditionally co-dependency and psychoanalytic perspectives have explained how PPDs appear to persevere in maintaining their relationships with a problem drinker. These perspectives assume that women (predominantly) become 'addicted' to their alcoholic, or that being enmeshed in such potentially damaging relationships satisfies deep unconscious needs. The current findings found scant evidence of such potentially dysfunctional motives; although not having specifically explored these women's pasts may have led to an under-reporting of co-dependent thoughts and actions. Further, psychoanalytic approaches might hold more relevance for analysis of the problem drinkers, as they *may* be the partner who brings unresolved attachment issues or intra-psychic conflict; but this is only a tentative suggestion through the women's perspective. Essentially, it seems wise to consider drink problems from a variety of psychological and practice perspectives.

This research also highlighted the relevance of both personal and institutional sources of meta-cognitions and lay theories, which appeared culturally and socially derived, rather than informed by psychology. Most women for example knew of the existence of Al-Anon and its philosophies regardless of whether they had become personally involved. The teachings of AA and Al-Anon seemed deeply embedded in the everyday lives of particularly Ruby and Christine and appeared to fuel their attempts to cherish optimism and banish pessimism ("stinking thinking").

The issue of whether it was 'right' or 'wrong' for the women to stay with their problem drinkers is also of central importance for counselling psychologists. We must attempt to understand and respect the 'frames of reference' of those who seek our help. We might usefully bear in mind that, "there is no one true way of managing [relationships] but rather we're all engaged in a process of finding out what works for us" (Barker, 2013: 7).

If couples therapy is sought, Hooper and Dryden (1991) believe that its primary focus should be conflict resolution, as conflict causes most distress. This in turn involves working on issues of communication, distorted emotional interchange, role conflict, differential personal development, and familial and social disapproval; all of influences were evidenced in this research. I argue however, that working with any/all of these aspects needs to be tempered with a flexible, 'courageous' and sometimes counter-intuitive mind-set. For example, forgiveness is usually viewed as a virtue, but recent thinking (e.g. McNulty, 2008) urges us to consider the potential drawbacks of consistently forgiving a spouse for destructive or unacceptable behaviour; such as Gemma forgiving Greg for her black-eye. Conversely, expressing anger is not always 'bad', and can enhance levels of social support from a partner. Sandra's rare expression of anger about Simon's 'undesirable visitors' precipitated him into apologising and seeking help for his drink problem. Clarke and Lemay (2010) urge us to look beyond the characteristics or processes per se and consider the context within individual relationships; using IPA was valuable in this respect.

Ultimately the women in this research seemed motivated to remain in a relationship with their partners. However, remaining required effort, largely coping effort, and a degree of balancing 'positive' and 'negative' phenomenology in an attempt to 'justify' their decisions to stay. Without empathy and understanding of the particular individual or couple we may defer to our own experiences of intimate relationships or rely on potentially erroneous assumptions. For example, it is easy to make the assumption that stability per se is 'good', although the stability of, for example, a concordant 'drinking partnerships' (Roberts and Leonard, 1998), is likely to be detrimental to both partners. If, after empathetic and sensitive counselling a

partner wishes to leave his or her problem drinker, then Hulson and Russell (1991) believe that we must use our professional skill in helping the couple to part as painlessly as possible.

Interestingly, Hooper and Dryden (1991) point out that couple counsellors are not required to undergo specific training as is the case for counselling individuals. This makes it even more important for the individual practitioner to be cognisant of their biases and assumptions. Whilst motivated to remain with their partners, the majority of my participants restricted their friendships and social networks. This 'voluntary isolation' may have been largely out of 'fear' that others would simply tell them to leave, or from seeking to avoid the judgement, 'competition' or 'insecurity' of other women (see Ussher, 1998); as a profession we do not want to be similarly shunned.

Finally, counselling psychologists also need to bear in mind that not everyone needs or would benefit from counselling; Fay being a case in point as she revealed her discomfort at a therapist *"puddling around in her relationship with her father"*. This conclusion is consistent with a growing realisation that there are complex and multiple pathways towards resilience (e.g. Bonanno, 2004; Bonanno, Wortman, Lehman, Tweed, Haring, Sonnega, Carr and Nesse, 2002; Cornford, 2007; Machin, and Spall, 2004; Norem and Chang, 2002; Parkes, 2006; Zhang, El-Jawahri and Prigerson, 2006).

Section D: Publishable Paper

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Where is Dr Jekyll now? An IPA analysis of the lived-experience of middle-aged female partners who remain with 'dry' male problem drinkers

Angela Gail Bradding

Abstract

This study sought to explore, analyse and interpret the lived experience of partners of problem drinkers such that it may make considered therapeutic recommendations for this potentially vulnerable group of individuals. Ten middle-aged female partners of male problem drinkers were interviewed in semi-structured interviews. Accounts were analysed using interpretative phenomenological analysis (IPA). Nine of the ten women were living with a 'dry' problem drinker at the time of the interview, and their narratives strongly evoked a 'journey'; entitled, *'drinker's path as partner's adversity and challenge'*. Six superordinate themes (and associated subthemes) were located along the journey. Namely: *Life before the drink problem; a creeping onset; in the thick of it; rock bottom; resurfacing reservedly; navigating new relationships*. This paper focused on the two 'dry' superordinate themes which saw the women reflecting, taking stock and to some extent preparing for the future with their 'dry' partner. There was however, a sense of uncertainty, reserve, and fragility about the narratives at this point. A prevailing theme throughout the evolution of the problem had been that of retrieving 'Dr Jekyll', but now he had re-surfaced, he did not seem quite as expected.

Key words: Adversity: alcoholism / alcohol misuse; interpretative phenomenological analysis (IPA); middle-age; partners; relationships.

Introduction

It seems likely that the vast majority of marriages or relationships start with excitement, commitment, and positive expectation for the future (Barker, 2013; Lemay and Clark, 2010). As a relationship progresses however, problems, conflicts, or even differences of opinion may threaten the often delicate balances or equilibriums (Hinchliffe, 1991) of conjoint living. Some partners, like those in this research, find themselves embroiled in the adversity and disruption of living with a problem drinker (Delargy, et al., 2011) which raises dilemmas about remaining or leaving the relationship (e.g. Howells and Orford; Copello and Orford, 2002).

There is a relatively large body of literature pertaining to the problem drinker him, or far less often herself, from unmotivated to change, drinking heavily, to treatment and into recovery, but far less is known about the experiences of living as a *partner* to a problem drinker (see Orford, 1984, 2001; Casswell et al., 2011).

Notably, there are a small number of qualitative explorations which vividly portray a very difficult and distressing partner experience (e.g. Reid, 2009; Velleman, 1993; Velleman et al. 1998). Velleman (1993) for example, highlighted a range of everyday difficulties which he notes can appear whatever the extent or pattern of the drinking problem; such as disruption of routines, financial, domestic and child-care difficulties and often relationship conflict and domestic violence. Similarly Orford et al., (1998b) identified a 'common core of experience' from interview data reported by affected family members in two contrasting sociocultural groups (England and Mexico): The problem drinker is unpleasant to be with; partners experience financial irregularities and difficulties; concerns over users health or performance; concerns over what the problem is doing to the whole family; personal anxiety or worry; feeling helpless or despairing; feeling low or depressed. Velleman et al.'s (1998a) *Living with Drink* conveys rich biographical accounts of six women's experiences of living with a problem drinker. The narratives revealed the shame, embarrassment, and the potential stigma of living with a problem drinker. Partners found themselves making strenuous and varied efforts to cope with difficult, often abusive behaviour. Reid (2009) carried out what I believe to be the only qualitative research study (thematic analysis) to focus exclusively on PPDs (four wives of male problem drinkers). She analysed data from semi-structured interviews and highlighted dominant themes notably 'blame' and 'responsibility'. Unsurprisingly then, remaining with a problem drinker is problematic and not the norm (Davis et al., 1974; Frankenstein et al., 1985; Halford and Osgarby, 1993; Jacob et al., 1983; O'Farrell and Bircher, 1987).

Often when PPDs are included in the literature it is primarily due to their potential role in helping, supporting or informing interventions for the problem drinker. For example: interventions which enlist PPDs to help motivate unmotivated drinkers into treatment (e.g. Miller et al. 1999); studies of marital problems as predictive of poor prognosis or lack of response in alcohol treatment programmes (e.g. Billings and Moos, 1983; Finney et al., 1983; Vanicelli et al., 1983); studies which report stressful marital interactions as precipitating a return to alcohol by previously 'dry' alcoholics (e.g. Marlatt and Gordon, 1985; O'Farrell, 1986; Maisto et al, 1988).

There are also a small number of studies which focus their therapeutic intervention on the PPD. (2001) Halford, Price, Kelly, Bouma and Young (2001) for example, compared two individual therapeutic approaches, (supportive counselling and stress management, and alcohol-focused couple therapy) designed to help female partners of male problem drinkers to deal with stress. Contrary to predictions there was no apparent difference between the interventions. All participants reported a reduction in stress and there seemed no significant effects on their men's drinking or relationship distress. Rychtarik and McGillicuddy (2005) sampled women from violent and non-violent relationships with problem drinkers to assess the relative influence of coping skills training (CST) and 12-step facilitation (TSF) interventions. Findings showed that both programmes lowered the women's levels of depression and lowered levels of their partner's drinking.

Yates (1988) took an innovative, albeit anecdotal stance to helping PPDs in their own right by identifying the *personal* circumstance of PPDs, rather than responses that had been designated a priori as 'enabling'. Individual coping strategies derived from interviews were sanctioned, and reassurance given to PPDs that their concerns about their partner are drinking was justified. Howells and Orford (2006), following from Yates (1988), report the development and preliminary evaluation of an intervention for PPDs, which was designed to reduce symptoms of stress and distress, and 'sacrificing' and 'engaged' coping (viewed as potentially damaging to wellbeing), to increase self-esteem. They concluded that PPDs do benefit from intervention specifically constructed to take account of their perspective. Even these studies however, which were designed to support the PPD in his/her own right, focused their attention on the pre-contemplator or heavy drinking phases, not recovery stages.

For further insight into a partner's perspective, we can usefully look towards the models or approaches underlying research endeavour and clinical work in the prevention and management of alcohol problems with 'significant others'. Here we need to selectively glean information that pertains to why a partner might remain with a problem drinker.

Orford (1984) provides a thorough and useful review of the early work with 'significant others' from English speaking countries and identified six perspectives[16]. Velleman et al. (1998a) also refer to six perspectives from which they 'translated' six PPDs narratives using each as

[16] These six perspectives comprised: The disturbed personality perspective; stress victim perspective; systems perspective; cultural patterning perspective; ecological perspective and the contagion perspective. He also acknowledged that other individual perspectives or different combinations of these six could be found.

a 'therapeutic lens'[17]. For this current research these models were amalgamated with relevant knowledge domains from mainstream psychology to create three perspectives which seem consistent with underpinning research and therapeutic work within counselling psychology; namely, individual differences perspective; cultural and community perspective and stress and coping perspective. Each provides a valuable body of knowledge that was 'bracketed' during the early phases of the analyses, but formed an integral part of IPA's 'double hermeneutic' as described in the method section. Collectively these perspectives have underpinned, guided and validated a diverse range of research and therapeutic endeavour of relevance to PPDs. Each approach also makes different assumptions about the role of partners, and consequently suggests different directions for therapeutic intervention and potential reasons to remain in partnership under difficult circumstances.

The 'individual differences perspective' for example encompassed the co-dependency model which is noted (by Orford, 1984) for its early and influential work with PPDs (e.g. Lewis, 1937; Whalen, 1953; Futterman, 1953). This stance views alcoholism is a disease or illness where the alcoholic is addicted to alcohol and the partner is 'addicted to the alcoholic'. This work established a vast and influential literature in a neglected area, and provided a platform for alternative approaches and modifications. There are however, a number of inherent methodological weaknesses, particularly in early studies, and this perspective is also viewed as responsible for pathologising *female* partners who contributed most of the data. Somewhat later, Beattie (1987), Cutland (1998), and Harper and Capdevilla (1990) refer to enabling actions which effectively collude with or reinforce the alcoholic's further descent into the illness, although again these are primarily seen as women's responsibility (Ussher, 1998).

Psychodynamic approaches in alcohol-related therapy (e.g. Cottman, 1998) also place heavy emphasis on personality variables as important determinants of responses to a problem drinker. A central assumption is that an individual's early experiences of interactions with their care-givers shapes later inter-subjective experiences and their interactions with significant others. Cottman (1998) proposes that a problem drinker might gain relief from his/her own deep-seated fears (e.g. Shinebourne and Smith, 2009) and suffering by gaining control over a partner in whom he has actively evoked those very fears. A PPD may seek to avoid being embroiled in such painful experiences through placation and compliance, and "tune [them]selves totally to other people's demands or expectations" (Cottman, 1998: 106).

[17] The Co-dependency (Cutland), coping (Orford), family systems (Vetere), and community (Fryer) almost 'mirror' the first four presented by Orford (1984). The remaining two, psychodynamic (Cottman) and feminist (Ussher) remain somewhat distinct.

A PPD adopting this stance might seem similarly enmeshed with their drinker as a co-dependent partner, and might benefit from greater psychological distance. In sum, co-dependency and psychodynamic approaches share the view that PPDs are to a large extent 'responsible' for maintaining a drink problem by their 'enabling' actions, being submissive, self-deprecating or overly-tolerant. In other words they remain with their problem drinker as a 'victim'.

The 'individual differences perspective' also incorporates mainstream conceptualisations of personality stemming from Allport's idiographic approach (e.g. Allport, 1946, [1937] 1961, 1946. 1953; Dumont, 2010). Referring to personality domains allows consideration of issues such as the nature of personality, the role of social and cultural 'mediators', and debates concerning the stability of personality characteristics (Dumont, 2010). In this way we allow the possibility that the expression of personality 'traits' is partly a function of interpretation and modification that occurs within the context of everyday lived experience (Willig, 2012). This view is also consistent with the 'cultural and community perspective' as envisioned by the current author.

The 'cultural and community perspective' provides a wider context for potentially relevant individual differences. For example meta-cognitive theory (e.g. Wells, 2000) reminds us that human beings hold beliefs *about* concepts and personality variables, which influence the expression and endorsement of pertinent constructs (also, Bhaskar, 1979, 1986; Harré, 1998, 2004); notably in this case the 'scripts' of Al-Anon (1979). Further Molden and Dweck (2006) endorse such 'lay theories' in their elucidation of the psychological process of self-regulation in the face of adversity; including the expectation of threat, conflict or rejection in close relationships. For example assigning stable, negative traits to explain a partners' antisocial behaviour, drinking in this case, leads to escalation of conflict and hostility (Bradbury and Fincham, 1992).

The 'stress and coping perspective' encompasses the most diverse range of theory and research, and provides valuable underpinnings for understanding many of the coping and relationship issues facing PPDs. For example, reference to alcohol-specific stress and coping, predominately Orford and colleagues (e.g. Brennan et al. 1994; Copello, Orford, Velleman, Templeton, and Krishnan, 2000a; Copello, Templeton, Krishnan, Orford, Velleman, 2000b; Copello, Orford, Hodgson, Tober and Barrett, 2002; Howell and Orford, 2006; Moos et al. (1990); Orford et al., 1976; 1992; 1998a,b,c, 2001; Philpott and Christie, 2008) has provided well founded and pragmatic definitions of coping (e.g. Orford, 1998) which are not limited to 'successful' coping, as in more formal mainstream definitions. Orford

et al. (2001) concluded that the structure of coping could best be described in terms of three factors: engaged; tolerant-inactive and withdrawal; only withdrawal was associated with the well-being of PPD's. Orford et al. (1998b) suggest that these three strategies are not totally independent, may result in functional or dysfunctional responses, and may be sensitive to the philosophies of those drawing the distinctions.

Mainstream theory and evidence, predominately the dynamic transactional views (developing from e.g. Lazarus and Launier, 1978; Lazarus and Folkman, 1984; Folkman and Lazarus, 1985; Folkman et al (1986) and more recently Folkman and Moskowitz, 2000, 2007) also inform the 'stress and coping perspective' by emphasising the mediating effects of a number of individual variables such as personality traits, predispositions to anxiety, amount and type of social support, and the influence of past experiences. A central tenet of a transactional approach is the *process* of reciprocal causation between the environment and the individual. Folkman and Lazarus (1985) concluded that, "a stressful encounter should be viewed as a dynamic unfolding process, not a static unitary event" (p.150).

Additionally, the stress and coping perspective includes: (i) systems theory (e.g. Steinglass, 1976, 1981; Steinglass, Bennett, Wollin and Reiss; 1987 Edwards and Steinglass, 1995) which focuses on the complex interconnections between family members' beliefs, behaviours and relationships, and the dynamic processes by which these develop and change over time. (ii) Interactional and mediational models and research (e.g. Cranford et al, 2011; Halford and Osgarby; 1993). (iii) 'catastrophe models of adversity' (e.g. Scheier and Carver 2002). The addition of these domains more accurately represents the dynamic complexity of life with a problem drinker. Similarly, Casswell et al. (2011: 1087) foregrounds the "less tangible impacts of alcohol on those other than the drinker" which are of primary importance in the current study.

In sum, three broad issues of relevance to counselling psychology emerge from reviewing the literature concerning the lives of PPDs: (i) PPDs seem vulnerable to a range of adverse consequences of living with a problem drinker, including concerns for themselves and their drinker; (ii) Many PPDs seem highly motivated to change their problem drinker, which creates opportunities for counselling psychologists to help couples in the same intervention programmes; (iii) Very little is known about the needs, and vulnerabilities of PPDs who have remained with their problem drinker into remission. Most theorising and research endeavour focuses on the problem drinker in-recovery (Hibbert and Best, 2011; Irving, 2011; White, 2007), the assumption being that their partners will be 'automatically' happy as a result. This

research aimed to explore this last issue with PPDs who had made a conjoint journey into recovery with their ‘Dr Jekyll’.

Method

Given the primary aim in this work is exploring the experiences of PPD the researcher adopts a qualitative perspective. Further, the primacy of experience suggests phenomenology as an ideal philosophical underpinning. A number of qualitative methodologies were considered and one in particular, Interpretative Phenomenological Analysis (IPA), appeared most appropriate.

IPA was first articulated by Smith (1994; 1996; Smith, Flowers and Osborne, 1997) and viewed as a qualitative approach which moves “beyond the divide between cognition and discourse” (Smith, 1996: 261), thus positioning it between post-positivism and extreme relativism, ‘strong’ social constructionism (Willig, 2012). This location allows: the existence of a reality independent of the knower; an exploration of human cognition, particularly perceptions, thoughts and attention processes; an acknowledgement of the important role of language in making sense of and articulating our experiences, and the assumption that individual subjectivities are embedded within their personal, social-economic and cultural histories.

Smith (2004) emphasises IPA’s specific approach as being defined by the three central features, namely idiographic, inductive and interrogative. In brief, IPA seeks to present interpretations of individual accounts (whilst being mindful of common themes) which are firmly embedded in the data, and interrogated with reference to the researcher’s subjectivity. In this way IPA attends to all aspects of the lived experience, including feelings, motivations and beliefs systems and how these might be expressed in behaviour and action (Eatough and Smith, 2013).

The focus on examining lived experience and how we make sense of such experience foregrounds IPA’s specific theoretical positioning within both phenomenology and hermeneutics respectively. Phenomenology, in that IPA seeks to explore personal experience and hermeneutics in that it also aims to interpret participants’ experience whilst recognising the central role of the researcher in this process. Further, in order for the researcher to both describe and interpret the participant’s world, a double hermeneutic is involved:

> "The participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world." (Smith, 2004: 40).

The employment of a double hermeneutic is consistent with my considered stance as 'research instrument' and appeals to my beliefs and opinions concerning progress and practice within counselling psychology.

Defining a drink problem:

Much existing literature imposes a pre-determined definition of alcoholism on participants, potentially masking their personal views and beliefs. The current researcher, like others (see review by Templeton et al., 2010) chose to use the term 'problem drinking' which uses the participants' individual frames of reference. Velleman's (1992) definition of problem drinking is argued here to be particularly valuable:

> "If someone's drinking causes problems for him or her, or for someone else, in any area of their lives, then that drinking is problematic" (ibid: 3).

This definition allows the problem drinker to be at any stage of their drinking path as long as problem drinking is an important consideration for the participant. It also acknowledges observations that partners are often unaware of the extent, quantity, or frequency of their partners drinking habits (e.g. Maslin et al., 1998) and allows scope for broad, individual 'diagnosis' to include a range of alcohol misuse from unsafe or irresponsible, to dependent or 'addicted'.

Recruitment

All participants are best described as self-selected. Eight were initially contacted from the databases of a variety of alcohol support organisations. The remaining two participants comprised one recruited through a personal contact and one who responded to my advert on an alcohol support website (Adfam) which they had approached for help in living with a problem drinker.

Table 1 below provides a summary of the participant's key biographical data.

Selection Criteria

The participants were *partners* of individuals whose drinking habits gave them cause for concern. These partners did not report or appear to be problem drinkers, and this non-problem drinking status was also confirmed by the alcohol support agencies (for eight) and self-disclosure to a third party for the remaining two. Evidence suggests that non-concordant

heterosexual couples (where only one partner, predominantly the male, has a drink problem) is more damaging to the relationship and individual well-being than if both partners drink to excess (e.g. Kahler et al, 2003; Moos et al. 2010; Walitzer and Dermen, 2004), particularly if the drinker is violent and antisocial (e.g. Floyd et al., 2006). The current research recruited discordant couples in an attempt to describe, understand and interpret the experience of the non-problem drinking partner, who would seem to be maximally exposed to potential harm. In this way we might provide insight into the lives of PPDs and facilitate the provision of effective, evidenced-based intervention for this potential client group.

More specifically, problem drinking had been an issue for the participant for a least a year and might be more inclined to share their experiences rather than so heavily involved in making sense of them (Davis, Nolen-Hoeksema and Larson, 1998). The problem drinker could be at any stage of their drinking path as long as problem drinking was an important consideration for the participant. Middle-age partners (using an extended definition – see Robinson, 2013a+b) were recruited given empirical evidence of coping and emotional benefits of this life-stage (Herzberg et al, 2006; Brennan et al. 1994), which resonated with the current researcher who is similarly middle-aged (see below).

Male and/or female partners from heterosexual partnerships were recruited as long as the drinker was the participant's sole partner and were currently living together. The couple needed to be born and continuously resident in the UK as cognitions, meta-cognitions and hence interpretations are seen to be influenced by cultural variation (e.g. Cheung, 1997). Finally neither partner had any major health problems (apart from those associated with problem drinking) as far as they are aware.

Interviews: Descriptions and Procedures

A face-to-face, one-to-one interview was conducted with each participant. Interviews took place in: the participant's home, the researcher's home, rooms provided by local Al-Anon groups and local support group offices. These interviews were semi-structured which allowed pre-determined questions to be responsive to the evolution of each interview.

The main focus of the interview consisted of attempts to elicit descriptions of predominately drinking-related events in the participant's life. The questions concerned: the drinkers' path and the partners' responses (actions, thoughts, emotions); particular events, incidents and occasions as appropriate; issues of responsibility; considering the future; current levels of discussion about the drink problem. The participants were provided with encouragement, prompts, and requests for elaboration and/or clarification where necessary; although these were as 'neutral' as possible to reduce leading the participant or distorting their narratives.

Ethical Issues

Ethical issues were considered from the outset and formed a compulsory part of this research undertaken in part-fulfilment of the first author's D(Psych) in Counselling Psychology, for City University. The researcher also accepted a personal and professional responsibility, as required by the codes of ethical conduct governing practice as a counselling psychologist, to consider the impact, implications and consequences of taking part in this project. This research involved exploring a personal and potentially distressing area of my participants' lives, requiring a balance of my needs for research data with the needs and rights of potentially vulnerable individuals. A qualified therapist had also been approached to provide counselling if this research precipitated distress that the researcher felt unable to handle personally. The interviewer also assumed a no-judgemental attitude and assumed an equal status relationship.

No interviews took place before participants had read the Participant Information Sheet, and read and signed the Informed Consent Form. Participants were informed they could withdraw at any point without incurring any adverse consequences. All Participants were debriefed at the end. They were also offered an opportunity to contact the researcher and/or research supervisor should any problems or questions arise after the research had finished. Written assurance of confidentiality was provided and reinforced a personal promise to provide anonymity.

Analysis procedures

The first stage of the IPA analysis 'proper' involved transcribing (verbatim) all interviews, then reading, rereading and familiarizing myself with the data (emersion). Completed transcripts were placed with generous margins on both sides, one for initial comments "which capture the participant's experience [on] on first encounters with the text" (Willig, 2013: 87); the other for potential themes. When the entire transcript had been systematically analysed, early emergent themes were reviewed and grouped or linked according to their apparent meaning for the participant. All transcripts were analysed in the same idiographic manner, although increasingly links across participants were presenting themselves.

Names of Participants (age)	Partnership details	Current status of the Drink Problem
Ruby and Ray (60) (61)	43 years (married 40)	Still drinking, Dr diagnosed Ray as alcoholic.
Denise and David (49) (48)	21 years (married 20)	In-recovery, 6-months.
Beverley and Ben (43) (42)	5 years (not married)	In-recovery, but Beverley suspects occasional drink
Christine and Colin (55) (59)	35 years (married 34)	In-recovery, 16-months, 3 previous relapses.
Mary and Martin (50) (51)	25 years (not married)	In recovery 18-months
Olivia and Oscar (48) (50)	36 years (married 24)	In-recovery, 4 and ½ years.
Gemma and Greg (53) (47)	11 years (not married)	In-recovery, 2-months
Sandra and Simon (68) (51)	12 years (not married)	In-recovery, 5 years
Heather and Henry (59) (60)	25 years (not married)	In-recovery, 10 years
Fay and Frank (63) (65)	30 years (married 13)	In-recovery, 12 years

Table 1: Biographical Information for the Ten Participants

Researcher's Personal Reflexivity

As the researcher who brought her 'double hermeneutic' I offer the following reflection on my subjectivity such that the reader can hold this in mind whilst you read the analytical commentaries that follow.

I am a white, middle-aged, married woman who for the last few years has been pursuing her quest of gaining a professional doctorate in counselling psychology. This endeavour has many 'drivers' and origins, including a strong desire to pass on some of my accumulated knowledge and experience of life and its adversity, but also its pleasures and potential for

personal growth. I have faced a number of difficult and distressing experiences, from bereavement to work-related problems, and also relationship adversity. I have lived with my current partner for approaching 40 years since I was a young undergraduate psychologist. In August 2001, whilst on holiday in Italy with our two teenage sons, he suffered a heart attack and needed open-heart surgery before we could return home. This traumatic event, and its many consequences changed our lives forever – we both had to face the fact that at some point our relationship will end, but in the meantime we make efforts to take life as it comes, and live it to the full. In essence I have a firm belief that jointly facing adversity can bring with it greater congruence in relationships and personal strength and happiness.

Findings

This retrospective analysis of the lives of ten female PPDs followed their journeys from 'normal' *'life before the drink problem'*, to a *'creeping onset',* where they gradually noticed that *"something odd going on"*, into the *'thick of it'*, a stressful and distressing experience, and eventually to *'rock bottom'* for nine of the women.

This article focuses on what are commonly termed the 'dry' stages (Steinglass, 1981) and explores the women's meaning-making during phases which literature does not seem to recognise as a problem. Specifically we focus on two superordinate themes and related subthemes as follows:

Superordinate Theme One - Resurfacing Reservedly

Subthemes:

- Revisiting responsibility
- Considering sunk costs
- Gaining strength through adversity

Superordinate Theme Two – Navigating New Relationships

Subthemes:

- Positive future expectations
- One day at a time
- Living alone together

Superordinate Theme One: Resurfacing Reservedly; taking stock

There are many indications that when the nine couples surface with a 'dry' problem drinker the women find themselves with time to reflect and take stock of their current reality.

Revisiting Responsibility: 'Rock bottom' acted as a watershed for the nine 'dry' couples and prompted both partners to revisit their respective responsibilities. The men come to realise that their drinking had become a problem and now 'reclaim' responsibility, or are left with it by their partners. The women begin to relinquish much of their earlier responsibility both for the drink problem, and the excessive 'parental' responsibility they had accrued by *'being mother'* (a coping strategy in the *'thick of it'*). However this distinction between the two partners masks the complexity inherent in the *two-way* interactions that make up a relationship.

> *At last he conceded that he had a problem.* [Fay]
>
> *The penny dropped, he knew <u>he</u> had to change*. [Mary]
>
> *He was so ashamed of himself and what drink was doing to his mind and his senses and his emotional life [that he went to AA for help].* [Sandra]

The three extracts above belie a long and difficult time in the *'thick of it'* in which the women had been heavily involved in trying to reach their pre-drink problem partner, '*Dr Jekyll';* eventually nine of them 'succeeded'. This signalled a future in which the men would 'rightly' take their own responsibility for their drinking, or now, non-drinking behaviour.

Similarly, Gemma recognised that Greg was motivated to change and *"he wanted [her] to get help, to help him"*. This is consistent with the clinical experience of those who facilitate joint involvement in working with drink problems (e.g. McCrady et al., 1999; Miller et al., 1999). Gemma agreed to have counselling (at the charitable organisation through which she was recruited) and gradually realised that although she could be supportive, or 'detach with love' (Cutland, 1998), only *Greg* could control his drinking,

Olivia provides a rich and compelling account of how she suddenly found herself relieved of the responsibility for Oscar's wellbeing. She had rushed him to the doctor following a suspected suicide attempt (paracetamol overdose). The doctor was just closing for the day and *"didn't want to know", s*o instead she left Oscar in a private rehab clinic and went home alone.

> *That was the sequence of events that changed everything. I just left him there, when he was telling me to go away … I was pleased just leaving someone else to deal with*

> *it. I felt I'd done my bit over the years and now someone else could sort it out. At that point there he decided he did want to do something about it and so far has.* [Olivia]

Olivia speaks for many of the women who seem to have decided upon a new regime and were adamant that that they did not want to go back, only forwards.

> *At that point, when he finally went into 'rehab' I knew it was never going to be the same if he came back and starting drinking again … I knew he could stop and it (drinking) was not going to carry on.* [Olivia]

Olivia's pivotal realisation is that Oscar knows how to stop drinking so she will *"never"* take full responsibility again.

Considering sunk costs: Maintaining a relationship requires continued commitment and effort from *both* partners, the occurrence of a drink problem however, saw the women's investments far outweigh those of her partner.

Hafenbrack (2013: 369) refers to the 'sunk cost bias' as the "tendency to continue an endeavour once an investment in money, effort or time has been made", which underlies an escalation of commitment or entrapment. Given this contemplative phase of their journey the following analyses capitalise on the retrospective nature of the women's narratives to foreground something of the 'costs' involved in remaining with a problem drinker. The 'calculation' of such costs however, necessitated a 'distillation' of individual narratives which errs their illustration towards prose rather than speech extracts. Given the word intensive approach to this subtheme I cannot do justice to the rich diversity of experience from all the participants, but present a concise summary.

Collectively and cumulatively the women's costs involved years of love, loyalty, commitment, support, consideration, and often 'putting themselves second' in the relationship (see Ussher, 1998). Christine for example, gave up a vibrant life in London with her close-knit family, to follow Colin to a small Essex town for his job. Mary stays out of a belief that Martin had experienced a difficult childhood and bouts of depression, so she stayed to help him.

> *"The only reason I stayed was because he needed me he knows he cannot survive, he knows how much he depends on me"* [Mary].

Olivia, however, seems to have invested the most in 'sunk-costs' as she waited 35 years for Oscar to reach 'rock bottom' and stop drinking.

> *When you've invested a lot you are have basically two choices – keep investing in the hope it comes good, or cutting your losses* [Olivia]

Along the way Olivia described making many sacrifices which included her decision *"not to risk having children"*.

For some women a significant factor in their remaining with their problem drinker is a sense of 'I've made my choice and can't go back'; whether out of love, pride, loyalty, or 'what will people think'; I almost entitled this subtheme 'I've made my bed so must lie on it'.

Gaining Strength through Adversity: A number of women not only survived the worst excesses of their partner's drink problem, they appear to have '*gained strength through adversity'*. For example,

> *I'm a different person, hope I'm a better person, more caring person.* [Christine]

I believe this is a genuine and accurate reflection of Christine's state of mind at interview, and argue that her expressed desire to help others lay behind her participation in this study. This commitment to spread a positive message is consistent with her faith in Jehovah and the philosophy of Al-Anon.

Olivia is more explicit about her newly discovered strength.

> *I told him, if he started drinking again I wouldn't stay around. I know he knows what he has to do to remain sober … before, I always thought if I left I was worried about his mental health, if he'd committed suicide, which he'd tried a couple of times, I'd have that on my conscience, because he'd think it was my fault, why did I leave. I thought if I stayed, I knew he was ill, I thought if I stayed and helped him minimise what was going on, it was better than leaving him to his own devises.* [Olivia]

This rich and illuminating extract reveals something of the 'binding factors', (e.g. evidence-based concerns about Oscar's mental health and suicide risk) that held Olivia in their relationship for *his* benefit, which resonates with *'being mother'*. Now she can spread her wings and may even 'fly away' if *"he started drinking again"*; this is powerful knowledge for Olivia.

> *"I've hardened up significantly [since rock bottom], much to his disgust".* [Beverley]

Beverley's gain in strength *("hardening up"*) resonates with Joseph and Linley's (2005) arguments for post-traumatic growth. These authors formulate a rebuilding of independent self or new found strength, autonomy and determination. At the time of the interview, Beverley was at a *"crossroads"* and typified a conflict between the old, give and tolerate self, and a new stronger self.

Superordinate Theme Two: Navigating New Relationships; life as a 'new' partner to a 'dry' Dr Jekyll

The pivotal interpretation in this superordinate theme is that neither the ex-problem drinker, nor their partner would ever be the same people who had lived together previously. For some women their 'here and now' lives seem to convey huge benefits, explored in the subtheme '*positive future expectations.* Others appear *cautiously* optimistic, hence the subtheme, *'one day at a time'*. Sandra stands out as experiencing significant ambivalence, even depression, and appears to be *'living together apart'* with Simon; again there is overlap, ambiguity, and 'mess'.

Positive future expectations: The three extracts below provide evidence of Christine's belief that the drink problem has gone for ever, which for her means that she can cease worrying about it.

> *Oh I'm so grateful those days are over, I can't tell you Angela I can go out in peace"* [Christine]
>
> *He's getting used to a life without alcohol. It just doesn't come into the equation any more. Now I don't have to worry about his behaviour* [Christine].
>
> *You've got to be positive that they'll stay in-recovery.* [Christine]

Christine's extracts needs to be read in the knowledge that Colin, unlike the other drinkers in-remission, has experienced three previous relapses and on the last occasion was acutely ill. I believe that Christine's experiences of relief and optimism, followed by deep disappointment and distress will have left a 'painful' mark on her. Cottman (1998) notes the enormous amount of uncertainty that remains even after partners appear to have stopped drinking. She believes they 'ask' whether it is safe to stop using strategies that have helped survival, and is it really the last time. These concerns must be very real for Christine and I believe she *does* worry about the possibility of relapse, but tries to rid herself of these 'forbidden' thoughts; often with the help of AA (and Al-Anon) philosophy.

> *As Colin's AA teachings say, we must banish 'stinking thinking'* [Christine]

Olivia also looks towards a very positive and happy future, although she reveals significant differences in her approach to towards maintaining her psychological well-being.

> *I thought, well that's finished (his drink problem) so I don't think back. To me it's as if it never happened. This new life has started.* [Olivia]

So now Olivia seems to be embracing life.

> *Just any normal things that's what I enjoy now, go out for a day or maybe just go shopping. Other people might find it boring, but if you haven't done that for most of your life then it's a bit of a novelty, enjoyment of simple things.* [Olivia]

I believe Olivia is now listening to her 'organismic', experiencing self, which Roger's (1957; 1961) believed facilitated self-actualisation. She also seems motivated by intrinsic rewards (*"simple things, normal things"*) which are argued as evidence of a 'healthy' organismic valuing process (Sheldon, Arndt and Houser-Marco, 2003).

One day at a time: Some women, whilst allowing for the possibility of a less difficult future, were more cautious in reviewing their current position.

> *Yeah I mean I take each day as it comes at the moment, just to see, I think it's very early days ... At the moment it's a bit like treading on egg shells or testing the water … We're not out of the woods yet*. [Gemma]

Gemma's extract resembles what could be termed 'cautious optimism'. Her stance struck me as cognitively active and reality-based in comparison to Christine's more 'static' and imperative-like encouragements. Gemma's optimism also appears more congruent and less illusory and seems consistent with Peeters et al.'s (1997) characterisation of 'unrealistic optimism'; requires congruence and cognitive vigilance in order to balance approach and avoidance.

> *I'm not a risk-taker… I'm cautious* [Gemma]

Denise's caution stems from her deep suspicions even now that David has stopped drinking.

> *I am terribly suspicious now but only cos I've got to be to protect him"* [Denise]

In sum, some women seem to be almost 'holding their breath' at this point, in Gemma's case it might be largely due to Greg's very recent abstinence (two months before our interview).

Living together apart: The remaining *'new relationship'* seems the farthest removed from the enthusiasm and happiness the women described at the beginning of the women's journeys. The essence of this theme is that the couple remain together but appear as two very independent individuals, rather than two mutually supportive partners. This theme seems to 'belong' almost exclusively to Sandra. Sadly, her narrative appears infused with self-doubt, apprehension and estrangement from Simon as they 'live together alone'.

Sandra indicates mild depression and a fear of the future.

> *I'm going to get older and I question everything, I'm thinking what's going to happen? I think of the future with trepidation* [Sandra]
>
> *We don't relate to each other like we used to* [Sandra]

Simon has been 'dry' for 5 years and has become an AA mentor which involves him being out of the house four or five times a week. This situation precipitates very mixed feelings for Sandra and raises important issues about the implications of one-person involvement in recovery programmes such as AA.

Sandra expresses significant ambivalence in-recovery as she does not seem to view Simon (as a non-drinker) as the same interesting *companion* as before.

> *He is a much better person and I am very, very pleased that he has made such a wonderful, I won't say recovery, because that's the wrong word* ***but*** *I thought it would be two or three meetings at most and then he won't go,* ***but*** *he did. He's gone from strength to strength* ***but*** *this is five years hence since he had a drink* ***but*** *he's gone to the other extreme. I mean I'm not saying that we don't jog along,* ***but*** *it's a bit superficial …* [Sandra]

Sandra appears to be struggling to find reasons to *be* optimistic, almost 'empty optimism', which seems sabotaged by her *"buts"* and disappointment at having unfulfilled optimistic expectations. This extract seems to represent what Harré (2004) argues is our human tendency to 'think about thinking'. Lyubomirsky et al., (2006) discuss such analytical thought on 'positive' events, like Simon's success at remaining dry and 'giving something back' to AA, as being potentially damaging to happiness and well-being. It seems that remission too can lead to a loss of *Dr Jekyll*.

Sandra's story in many ways highlights the quality of relationship that is conducive to happiness, by highlighting what is missing. In other words there needs to be companionship, quality time together, investment, common ground, fun, sharing and a 'here and now' quality.

Discussion

This paper focuses on the 'recovery' stages of the couples' journey where existing literature seems to assume that the stress and distress for PPDs is over. This assumption is made despite literature which acknowledges that 'recovery' for the problem drinker is an extended process, which involves more than merely giving up the drink (e.g. Hibbert and Best, 2011; Irving, 2011), and heralds the start of significant identity changes (e.g. Laudet, 2007; Shineborne and Smith, 2009). I argue that that the 'recovery' stages also signal the start of

significant identity changes for the women, some of which have a significant impact on the sense of wellbeing and the dynamics of their relationships.

In order to provide a credible and coherent account of why the women might have stayed with their partners throughout a very difficult journey, and why they seem to experience some ambiguity with their current *'dry Mr Jekyll'*, I set the 'end' of their journey in its earlier context and existing therapeutic approaches.

All ten women started their stories by positioning themselves in 'normal' happy times where drink featured in their lives, but as a socially acceptable part of everyday life and work. There seemed no suggestion that either partner were 'out of the ordinary' in this respect. Gradually however, things changed, and the women started to notice *"odd"* drinking and social behaviour, which seemed to have taken them unawares. Before they know it they are embroiled in the *'thick of it'* and expend many and various efforts to cope; mainly directed towards 'retrieving' their previous 'good' partner, *'Dr Jekyll'* whilst increasing finding 'Mr Hyde', the 'bad' partner. In other words, this study found scant evidence to support traditional co-dependency or psychoanalytic perspectives which assume that women (predominantly) become 'addicted' to their alcoholic, or that being enmeshed in such potentially damaging relationships satisfies deep unconscious needs. The prevailing view was that the arrival of a drink problem was a totally unpleasant and unwanted intrusion in these women's lives, which resonates with the stress and coping perspective. Although, I accept that not having specifically explored these women's pasts may have led to an under-reporting of co-dependent thoughts and actions. Neither did I explicitly explore the women's material circumstances and the ease at which they could find the means or garner a sufficient sense of personal agency with which to leave their relationship; see Ussher's (1998) interpretation of the PPDs in *Living with Drink*.

Returning to the end of the stories we find most of the women are pleased, relieved and grateful that *"alcohol doesn't come into the equation anymore"* [Christine] *and "this new life has started"* [Olivia]. There is a sense that the coping and the 'sunk costs' have been worth it, rather than a sense of loss at not requiring so-called 'enabling actions' (Cutland, 1998); which effectively collude or reinforce the drinker's ability to drink. Even Sandra, who appears least happy in her *'new relationship'*, appreciates the benefits of Simon being in-recovery' as he is a *"much better person"*. It also seems that having survived *'rock bottom'*, *both* partners have an opportunity to navigate new ways of being for the benefit of themselves and their relationship.

For the women, the relief of *'rock bottom'* gives them the chance to reflect and take stock. Their thoughts seem to prioritise their current and future responsibility ('re-visiting responsibility'), decisions as to whether they continue to 'invest' or not in the relationship ('considering sunk costs'), and what they have learned from their experiences ('gaining strength through adversity'). Olivia for example, seems particularly determined not to return to the roles of *'social conscience'* or being Oscar's *'mother'* (as seen earlier). This offers her the chance to live her own life more fully and enjoy a mutually negotiated shared future. This impetus for *"simple pleasures"* and *"freedom"* might facilitate a more 'open' environment where Oscar can give *sober* free expression to parts of himself (Shineborne and Smith, 2009) without fearing judgement. Similarly, Christine believes she has become a *"better person"* and feels more able to tell her story in the service of helping others. Beverley has also *"toughened up",* much to Ben's dislike, which highlights a key paradox in working therapeutically with partners; what might be conducive to psychological growth for one partner, may be potentially distressing for the other.

In essence the nine women decided to remain with their partner and continue to invest their time, love and commitment, but without the excessive responsibility. There is also a sense that there is 'no going back, only forwards'. This positivity and energy for the future is clearly seen in Christine's narratives as she extolls the virtues of a *"life without drink"*. However Christine's *"got to be positive"*, coupled with her and Colin's shared understanding of pessimism (from AA and Al-Anon), act as optimism-rallying conditional imperatives and may lead to 'too much optimism'. Cherishing optimism and banishing pessimism *("stinking thinking"*) may lead to under-estimating the risk of relapse and hence eventual disappointment (e.g. Held, 2004, Sweeny, Carroll and Shepperd, 2006).

Concerns with people's tendencies to embrace extremes need to be taken seriously by counselling psychologists, as it is important to actively listen and attempt to understand both the 'positive' and the 'negative' of client presentations; else this amounts to *conditional* positive regard. Effectively therapists need to be alert for, and ready to 'catch the leading edge of awareness' (Gendlin, 1981), and help individuals face their fears and uncertainties for future protection. Christine for example, described what she called *"flashbacks"* when Colin visited the garden shed (as this was where he used to hide and drink). She immediately leapt in to tell me that it *"was not often and not all the time"*, but worrying about Colin relapsing must be very 'real' to Christine and she would benefit from a 'safe' outlet for her anxieties (as I got the impression she did not discuss these thoughts with Colin for fear of 'tempting fate').

Christine's 'strictly controlled' anxieties were interpreted as part of an underlying fragility of the 'dry' themes. There was a sense of 'surface' calm and relief which masked a more implicit worry of both relapse, and an unsettlement in terms of not quite recognising their 'dry' *Dr Jekyll*. For example, Mary now felt rather sorry for Martin as he had become a *"solitary animal"*, Gemma was conscious of not mentioning drink explicitly in a way she did before, and Sandra seems most disconcerted of all.

Sandra's story seemed infused with depressed thinking and what a CBT therapist might identify as 'logic errors'. Sandra's narrative also provided the most explicit example of what could be termed 'ambivalence in-remission' as she realises she 'should' be really pleased and proud of him, but her emotional experience is heavily infused with sadness and lack of positive expectation for the future. Sandra's situation also highlighted a need for therapists to facilitate expression of thoughts and feeling which people might be potentially ashamed of, or where they are overly concerned about what others might think. In other words, PPDs need, even in the 'dry' stages, a therapeutic approach which provides acceptance, sensitivity and recognition that their concerns might include feelings of disloyalty and reluctance to seek help.

At its heart this exploration has been concerned to understand how an individual can live what they consider to be a happy life, which for the majority of people involves making accommodations 'necessary' for living with a fellow human being in an intimate relationship. Living with a problem drinker had involved serious additional challenges to the women's ability to remain, but having made that decision, I would like to hope that they are able to, not quite 'start afresh', but certainly be open to the possibility that that life can take 'positive' as well as 'negative' turns and be ready to embrace those, both personally and as a couple.

Essentially practitioners need to be very mindful of individual differences and their client's particular contexts, but also be unafraid of helping their clients to face difficult 'truths' about life's 'fairness' or otherwise, and to reflect on the challenges of congruent self-regulation.

> "… the self-regulation people are able to immediately exercise in response to setbacks, particularly when cherished abilities and identities are directly threatened, can often determine whether they are able to recover and resume pursuit of their larger goals" (Molden and Dweck, 2006: 194).

Further, I argue that individuals might benefit from having the courage to tolerate some uncertainty (Wilson et al., 2005) and pessimism (Thompson, 2004), in the hope that pleasant and unexpected events will surpass expectations.

Some Strengths and Limitations:

This IPA analysis has allowed a search for common patterns *and* individual differences within the lived experience of being a partner of a problem drinker. It has added 'real' human reference to much of the pre-existing evidence of life with the adversity and potentially challenge related growth that is involved in living with a problem drinker. We have seen something of how these women have engaged in thoughtful, intentional, self-regulatory activity (e.g. Bhaskar, 1979, 1986; Harré, 1998, 2004; Robson, 2011; Smith et al. 1995, Willig, 2001; 2012; 2013). It has also allowed the women "to think, talk and be heard" (Wagstaff, 2014: 3). I also agree with Holland (2014, in Wagstaff, 2014), a fellow therapist, that from a therapeutic background, the gentle probing with individuals (at interview) followed by mindful interpretation felt 'natural and supportive' and to some extent 'gives something back' to the participants, which is ethically commendable (Robson, 2011).

Regarding limitations, I am conscious of not exploring the emotional aspects of the women's lived experience as deeply as I might. We have seen a range of both 'positive' and 'negative' emotions, and 'emotional blends' all of which seem to evade adequate description (Butt, 1999). Many of these emotions, most notably, love, compassion, gratitude, sadness, and anger would benefit from further analysis as to their nature and intent (Butt, 1999), their role in resilience and meaning-making in stressful situations (e.g. Tugade and Fredrickson, 2004) and the effects of their dynamic changes over time (e.g. Folkman and Lazarus, 1985).

I also acknowledge that my analyses (and therefore my 'double hermeneutical' contribution) were more heavily informed by person-centred and cognitive-behavioural approaches (including so called third-wave approaches, such as mindfulness), than by psychoanalytic formulations. I intend to 'rebalance' the analyses in this respect in the near future, but in the meantime welcome comment from those already better informed.

Finally, throughout the analyses I was mindful of the 'quality criteria' which made for a credible and communicable piece of research (e.g. Elliot et al., 1999). Specifically I have been open and transparent, grounded my themes and discussions in the narratives, and aimed for intelligibility and theoretical sensitivity. I have also provided something of me and my subjectivity in this paper, but appreciate that my subjectivity is not replicable or totally knowable (even to myself) and will have limited discussion according to distortions or inadequacies in my scholarship.

Future research:

One of the main areas of future research would be to conduct similar IPA explorations with different participant groups. For example, it would be valuable see whether male PPDs describe similar or differing experiences. Likewise I would value the opportunity to explore the lived experience of the problem drinker themselves, male or female. Analysing the later stages of the journey I started to wonder how far the different approaches to 'recovery' were related to the amount of time in the *'thick of it'* and the time since *'rock bottom'*. Hibbert and Best (2001) differentiate between 'sustained recovery' (up to 5-years) and 'stable recovery' (5-years plus), which might have a bearing on emotional experience of the kind that Howells and Orford (2006) noted in relation to Folkman and Lazarus's (1985) changes in intensity and type over time.

There were also some themes within the current study that might valuably be explored at greater depth and complexity. For example an early theme, *'praise for the drinker'* became rather subsumed under more dominant themes that threaded their way through the analyses, and seemed to become 'love as a reason for staying' in the dry themes presented in this paper. This suggestion is consistent with my earlier discussion on the limited attention to emotional experience in general.

Finally, one of my most recent thoughts regarding my interpretations of the 'dry' themes was whether a *'dry Dr Jekyll'* might be compared to 'the return of a prodigal son'. It seems that many of the women accepted their men back after his 'disappearance' at *'rock bottom'*, but not quite in the unconditional way of most parents. I look forward to reflecting further on this myself.

Ethics:

This study gave time to a marginalized group of people and provided a 'safe' and non-judgemental space, which allowed an opportunity for some 'normalising' of their difficult experiences. It may even have facilitated some positive reappraisal which might enhance the participant's lives and those of their partner. Certainly my experience of the women at interview suggested that all found the experience bearable and some, most notably, Fay, Gemma and Christine, seemed to welcome the opportunity to talk about their experiences and found me a 'good' listener. However, research involving even potential change, as in this research, poses additional ethical challenges (Robson, 2011). Accordingly, care was taken not to offer judgement or specific 'advice'.

Conclusion

I believe that this current exploration has added to the understanding of ‘lived experience’ of being a female partner of a male problem drinker. It has shown something of the complexity and self-interpreting, self-reflecting nature of attempting to balance concerns for self, partner and to some extent ‘wider society’ in terms of trying to ‘fit in’ and live a happy, ‘normal’ life.

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At present these are incorporated into the main reference list.

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Appendix 1

The Twelve Steps: Al-Anon

1. We admitted when we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to God ***as we understood Him***.
4. Made a searching and moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked him to remove our shortcomings.
8. Made a list of all persons we had harmed, and become willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God ***as we understood Him***, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.

Appendix 3

Early Theming Efforts

The following material provides a selection of extracts the early themes.

The 'tag' of extracts is derived from the first three letters of their *real* names (at this stage I had not provided pseudonyms) so they do not match with the names of the participants in the portfolio and page location. (…)'s denotes context placed in another theme. […] denotes my comments or process / subjectivity indicators.

[i] Noticing the Problem

Noticing the Problem was one of the early and largest themes. In its first evolution it contained anything related to noting the problem that had not been placed somewhere more specific or appropriate. The majority of this theme eventually became *Drinkers Path as Partner's Adversity and Challenge* (see below)

The extract below shows how the themes looked straight after being typed into the computer. (…)'s mean that this content is more appropriately placed in another theme but are recorded with the un-bracketed content to provide context. […]'s denote my interpretations or comment. Gradually, as the process evolved, I would add (…)'s and […]'s and/or completely reallocate extracts. Also I occasionally include my comments to allow the participant's comments to be contextualised.

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- LinA8 Slept with bag down side of bed and didn't leave the room without money therefore (I didn't know … didn't trust him).
- LinA8 Co. It must have been exhausting? Yes – thinking of all sorts, all the time.
- LinA8 Doctor prescribed anti-depressants (before realised the full extent)
- LinA8 Doctor checked his liver and said "high enzymes" you've got to…? [Couldn't bring herself to say stop drinking?] – So he stopped for 3 months – "So he could do it" then back to doctor's - Doctor said you're fine now – so he went back to drink again. "See this is the alcoholic thinking you see" [not Don – her husband?!].
- LinA9 Few months on, few months off.
- LinA9 Clinic for a month (when he got really bad).
- LinA9 Co. It's been a long journey for you? – Yes.

- BerAP6/ (After dog and police) we moved and he would get angry (he wouldn't hit) at stupid little things.
- BerAP6/Usually (he would get angry) just as I was going to bed, he would start to talk absolute rubbish.
- BerAP6/ (B stated) that the 'stupid' bedtime talk was done "just to have an argument".
- BerAP6/ He would come after me just to carry on an argument (she agreed this was deliberate).
- BerAP6/ The drink made it worse (his raising problems before bedtime).
- BerAP6/ He wanted to share things with me that weren't my problem – like if he owed money.
- BerAP6/ He would talk about things at the wrong time.
- BerAP6/ Roger would try to 'pin her' (B) down to talk just before bed.
- BerAP7/ He carried on drinking and he got more and more violent ("well not so much violence, you can't really call it violence. He pushed me into corners so that I would listen to what he had to say").
- BerAP7/ On one occasion he put his hand up and caught me under my chin, just to stop me from moving.
- BerAP7/Last year he gave me a black eye (last Easter) (after the dog and police) – something provoked him, or he got provoked – I'm not going to say it was me because he was angry anyway.

The following extracts are all in a similarly 'raw' state to "Noticing the Problem" – I have provided a selection from a range of themes, some large and some relatively small.

[ii] Coping and Not Coping

PeaA p13 – It didn't bother me, it didn't bother me [picking up kids because C couldn't because of drink].
PeaA p13 – Me – you were adapting and working your way round things? [like always driving to pick up kids] – yes that's right.
PeaA p14 – I carried on going to work because school to be honest was just normality (after knowledge of affair).
PeaA p14 – The children (school children at work) didn't know what was going on (affair), hadn't got a clue what was going on in my life .. they kept me going.
PeaA p15 – I struggled with work for about a month (after affair).
PeaA p15 – Struggled through OFSTED inspection (after affair).
PeaA p15 – I was on sleeping pills (after affair).
PeaA p15 – I was on anti-depressants (after affair).
END OF TRANCH 3
LorrA p9 – Maybe that [being able to separate work and home and just function in each environment as dictated by that reality] was my salvation [strategy for coping?] that I didn't spend all day worrying about (home at work and work at home).

LorrA p12 – (I know now that he has no excuses and can't say) oh it's all your fault when he knows it's his fault. [I got a sense here that L has recognised that she is now married to an equal, an equally competent human being who can think rationally about where responsibility lies, as opposed to struggling on her own to cope with him as an alcohol addled presence?].

DiaA p3 – That's (the fact that it helped) down to her (counsellor) so yes she helped me. [I see this as D being helped to cope?].

DiaA p5 – I really struggled with it (not spreading "malicious rumours" about J) but I managed/coped, didn't tell.
DiaA p8 – [Me – What happened to turn things around (when you were traumatised and not coping)?]. You've got to get on with it, haven't you? I've got two children. [Resilience, mustering her resources, 'dragging' herself out of her trauma].
DiaA p8 – I was there (new house) on my own and everything, everything was going wrong and I couldn't cope, so there was kind of lots of stressful situations.
DiaA p8 - .. and (then) the puppy wee'd on the floor It was the final straw, on a new carpet that we'd had laid the week before we moved in. [Relates to the General Adaptation Syndrome, point of exhaustion].
Peaap11. It was a Thursday night and I was going to go to my 1st Al-anon meeting [when C told me he was going to Australia].
Peaap12. I told myself "not to be silly" (about affair thought)
BreA p5 – A lot of drinking (because of guilt).

[iii] Insight

INSIGHTS - 2

peaap8. He can't say sorry – he finds it very difficult to say sorry (re I'm not the child's father). In fact that the first time I've realised that, I've realise that [he can't say sorry] but in connection with the children not mine]. He can't say sorry it's just too painful I think to say sorry. [I get the impression that P maybe stronger and more balanced emotionally]
peaap16. I realised there was a pattern to how I felt and the way I behaved [not completely explicit about this but relates to knowing she still loved him and trying to put that aside]
peaap20. I've learnt an awful lot about me
peaap20. Me – you've been on a long tortuous journey haven't you? – Yes it's been a journey you're absolutely right which all of us at Al-anon are still on.
breap3. Looking back he (ex) was definitely an alcoholic

[iii] Hope / Optimism

peaap4. We were really very happy, very happy [early married life before children]
peaap4. Going back to work with Polly was an easy option for me – life was perfect really. [Ok it wasn't obviously.[perfect] because no life is...[but] often when you look back life seems idyllic]
peaap4. Yes, [I was] happy, very happy [I get a strong sense that she is looking back very wistfully / rose tinted spectacles and is comparing her life then and now – very dream like quality / tone in her voice]
peaap5. [The fact we had two kids] turned out to be the right thing
peaap5. The two kids are very close
peaap5. Chris was absolutely wonderful during all the time [when I had breast cancer] he was absolutely fantastic.
peaap5. All the way through they [doctors] were convinced it was nothing [not breast cancer]], but I had the biopsy done and it was cancer. [This was described in a very calm manner and I felt that she had been comforted / 'persuaded' by the doctor's optimism?]
peaap5. P felt herself in a position to be the sole breadwinner a year because she judged the family to be in a "good" position. [this is quite a generous and liberated stance?]
peaap6. "He was just extraordinary, just extraordinary". – "just looking after me, nothing was too much trouble
peaap6. [France seemed a good place to start [to live abroad] – when P was 7 and R was 4.
peaap6. Had a fantastic time in S. France for 4 years – making lots of friends, local people and people who work at C's company, four very, very happy years.

peaap6. Three years before France I helped a next door neighbour organise a party (in village hall) for her parents who were visiting. She and I had a great time preparing the food, taking it over a good time was had by all.
peaap6. Luckily the children weren't with us at the village hall do [where C had his fight] – they were elsewhere being looked after by two friends of ours
peaap6. It was fun a great sense of community [talking about the dances at the village hall and in particular the dance with the kerfuffle]
peaap9. [so] of course I came home with wings on my feet thinking whehay [after he told me he'd get help with his drink problem] – [P is good at taking / accepting the positive when it comes her way / not looking the gift horse in the mouth]

[iv] Not coping – had started to sort this theme here

LinAp8 - I lost a lot of weight – "I couldn't eat"…"stressed out".
Peaap10. I didn't know what to do [re relationship and not feeling right]
Peaap13. You probably didn't know how to deal with things (like when you were sitting in front of TV) – no I didn't, no I didn't, I didn't.
Peaap12. My world fell apart, because I hadn't seen it coming.
Peaap13. I didn't know what to do...I didn't know how to....
Peaap13. I was just lost, I was lost, completely lost
Peaap14. I hadn't eaten, I don't think, or eaten very very little. I just felt sick all the time.
Peaap16. I've tried, but I really can't do it anymore
Peaap16. What do I do, he wants to come back again. (conflict because she still loved him)
Peaap17. I'm not sure I can keep doing this (him coming over for a meal and then going their separate ways.
Breap5. I was very, very depressed then (after leaving ex)
BreA p11 – (I) broke down you know (at confirmation over call girl).
BreA p11 – So you know this is crisis point (coming home early and finding call girl in house).
Judap2. That (when I'd left him) is when I nearly broke down and I thought I was having a nervous breakdown.
Judap8. One of the problems (after returning) was I was so tired, I was always tired
Judap8. I was not coping with a very stressful job anyway, and there wasn't much support there. Move – [coping?]
DiaA p11 – I felt completely isolated, there was nobody (for me) no phone calls (after crisis).
DiaA p11 – I spoke to A's key worker at Focus in B St M and I was sobbing on the phone saying I need some help and I don't know what to do and she said, well what do you want us to do about it?

[v] Drinker's Life Without Drink / AA for The Drinker: (much of these themes eventually became part of Drinker's Path as Partner's Adversity).

BeraP10. R's daughter phoned up and said her mother wasn't speaking to her, hasn't talked to her for 2 weeks – This didn't help and he said, "I felt I could have had a drink then".
BeraP11/R stayed strong (after wanting a drink after his daughter phoned with problems) and it passed (desire for a drink).
BeraP11/R planned to go out Friday next.

BeraP11/A alcohol worker came in for the first 2 days and were returning on the Friday and then just very occasionally.
BeraP11/Now it's down to R to make sure he stays off the drink.
BeraP11/R did have a job for the first couple of 'dry' weeks.
BeraP11/Roger was starting a new job the week of Interview A.
BeraP12/He has a bath in the evening and then cocoa before bed.
BeraP12/Roger not sleeping very well as he is stressed about his new job.
BeraP12/A friend promised to return a chainsaw (that he had been mending) at 5pm but was late (after bath and cocoa) turned up drunk. This friend was drunk and "talking nonsense" and R got "uptight… and wound up and he couldn't go to bed". (I said, it must've been an interesting experience for R to see someone drunk – Beryl agreed…"Yeah, see what it's like).
BeraP12/R didn't approve of his friend coming in drunk when he knew R was detoxing/not drinking.
BeraP13/R's not a person to go in the pub and have a drink, "he's not a pub drinker…he will have an orange and soda".
BeraP13/"It's at home he drinks" (when he was drinking).
BeraP13/"There was only once he said he might've had a drink but that soon passed".
BeraP15/R doesn't like B having to face challenging behaviour.
BeraP16/(R)"has got very few close friends".
BeraP16/(R)"started going to the gym because he's got a weight problem, because of the drink problem" – B would like him to return.
BeraP16/R fancies chocolate sometimes.
BeraP16/R has high blood pressure, which the Doctor is keeping an eye on.
PeaA p6 – C did the shopping, cooked and served the meal, then left us and brought coffee later; he left us to it.
PeaA p7 – C didn't know whether to press charges or not and asked the police for advice (the police advised him to just in case there was a court case, so he agreed).
PeaA p7 – The young man [who hit C] pleaded guilty so we didn't have to go to court.
PeaA p7 – From that day [of the fight] C changed completely.

[vi] Making Excuses / Conceding to Partner (v small) / Justifying behaviour

LinaP5 (D always liked a drink) – I mean who doesn't like to have a drink, we all like to have a drink, but in moderation of course [is Linda trying to say that D's drink problem grew out from a 'normal' human pleasurable activity like social drinking? She also reveals her being in moderation – i.e. this is in some sense a judgement of D's non-moderate drinking).
LinaP5 We couldn't afford it [in relation to what she feels as the young drinking culture) – some jealousy or perhaps anger (?) at D spending <u>their</u> money on alcohol?]
LinaP5 D didn't have to have a lot, especially if he was tired – only 1 or 2 and he could come across as drunk.
LinaP5 It didn't happen every time (D falling asleep).
LinaP6 "I just think he's tired and really what he drank was really peanuts"…"I mean thankfully he was never a bottle of vodka a day guy…he just drank strong beers and that horrible cider stuff".
LinaP6 "Sometimes he was fine (when "told off") at other times he wasn't (but) he never did anything outrageous… it was never anything like that (doesn't specify what) – "he would just sit quietly in the corner, he might even nod off". [Like a child/baby?]…Like when my niece gets drunk she gets absolutely mad…but D goes the other way, he goes really quiet.

LinaP6 D didn't know when to stop and had just another which might knock him out especially when he was tired.
BeraP8 I made excuses at work that I'd fallen over on the ice (because of black eye) – because it was icy I got away with it.

[vii] Lay Theories

LorrA p6 – Whereas if you do something sober then that's a different matter (i.e. judgement exists whereas it doesn't when you're drunk) because you've been able to think about consequences and outcomes so if someone does something when they're sober then if you think of this was a good idea.
DiaA p6 – It's just pointless (having counselling at that time) because you know, you can't change somebody who's taking so much cocaine and drinking, it's just pointless.
DiaA p11 – I do feel angry about it (hearing stories about the damage alcohol abuse can do to people's lives) because I think of all the people who are dying through cancer and through things of no fault of their own and drug and alcohol abuse is just unnecessary.

[viii] Incomprehension [Not quite right?]

LinA - I <u>didn't understand</u> (the relapse)
Peaap20. I don't know where we're going from that (difficulties with children). I just don't know.
BreA p10 – I don't know what, I can't remember the build up to it (going to AA). [Not quite incomprehension? more lack of clarity?]
BreA p14 – But I just don't know (about the future).
Breap4. I don't know how much of this is accurate (of issues with his wife).

[ix] Self-criticism

Peaap13. I was very, very, very overweight.
Peaap13. I mean I can't believe how pathetic I was (not moving in front of TV)

[x] Negative Emotions

LinA - <u>Frustration</u> that he'd been there before – why?
LinaA - L cleans for D's Doctor – so embarrassment and shame (she hadn't said anything job but/so was embarrassed when he came to visit D).
LinA - If he drank he slurred and she didn't want people to think he was drunk.
BerA - It was frightening (the incident after the dog barking). It was absolutely terrifying. They (neighbours) were terrified as well. There was a bloke shaking in his boots

Movements towards Homogeneity and Distinctiveness

The first task was to incorporate the […]'ed raw themes (as listed above) into what seemed like more suitable locations. This involved cutting and pasting and often adding extra comments in […]'s for future reference.

Towards Themes

I carried out a thorough and systematic review of all remaining themes which involved initial clustering. This stage was particularly important and complex for the larger themes such as “Partner’s Responses” which, in its first evolution was very heterogeneous. At this stage I also returned to transcripts many times, made reference to literature as appropriate and had discussion with my supervisor.

[i] The Negative

(LinAp4) Even Don’s ‘quiet’ R to drink is embarrassing but “there you are” [resignation?].
BeraP7 [Got angry] R trying to wake her to talk about “rubbish…stupid stuff” would make her angry.
BeraP16 [Dislike of eating binges unattractive] B found R’s eating binges (after drinking) very unattractive.
peaAp13 I was in a depression again (after affair)
peaAp17 Look this is so difficult for me (meeting and being hugged and kissed) you’re going back to her house, her bed presumably.
BreA p5 – I had become very, very depressed (after ex died).
BreA p5 – I moved back (to ex) and that in itself because I’d got to the point in my life that I thought I cannot get on with anybody [learned helplessness].
BreA p5 – I couldn’t get on with my husband (ex).
BreA p5 – I had a bad time, relationship-wise, always with my mother.
BreA p8 – I thought, oh my God (when he was “gone” in the restaurant).
BreA p8 – I begin to think (on birthday) what’s the matter with this man?
BreA p12 – The relationship has changed in that I do feel resentful that it has taken over his life, this AA because he’s been so successful.
BreA p12 – (Me – that’s a big commitment isn’t it, 3-4 nights a week). Yes and it’s a long time to be leaving me [bored and lonely].
BreA p12 – You see that’s (left 3 or 4 nights a week) why I say the relationship has changed.

Judap2. Me and A had to run upstairs (when he turned the table over in a temper)
udap2. I <u>really</u> thought he was going to commit some degree of domestic violence (after he up ended the table).
Judap2. I was really frightened when he lost his temper like that (turning over the table)

Judap2. I had to have time off work and that’s when I really hated him.
Judap2. I used to tell him for weeks, I really hate you,
Judap5. I didn’t want him to touch me so there was no intimacy there, that goes doesn’t it?
Lorap3. I’d said no (before the Menorca episode) because I didn’t fancy going out, I could hear he’d had a lot to drink.
Lorap11. I’d come home and he’d have people round and they’d been drinking all day, I might fly into a rage, but not actually arguing. [interestingly L feels the need to almost justify the fact they she flew into a rage when it appears to be a reasonable response to the situation, most people would be unhappy at coming home from work, earning money to ‘survive’ to a husband who was drinking her money away?]
LorrA p12 – Sometimes I have flashbacks and think oh was life really like that?

DiaA p5 – We'd end up rowing (when he'd had a lot to drink), we'd end up rowing about stupid, trivial things [interesting that she says stupid and trivial things – shows her implicit thoughts about A's ability to control himself etc?] [I asked if she could remember any of those rows] No, not really.
DiaA p7 – (I thought) what an idiot (A).
DiaA p7 – I spoke to him (A) and he was in a really bad way.
DiaA p9 – In the end I had to buy the house for us (because of A's serious financial problems and debts).
DiaA p9 – (After no contact, as I was expecting) I wrote a letter (to his family) to say how I was feeling about A, you know, I loved him ["praise/love for drinker"].
DiaA p9 – I saw him drink it (the champagne, when he was supposed to be not drinking) and I just hated it.

DiaA p10 – I thought he was this sort of person that he was when I was with him, really good job, quite successful, he was fun, he was quite self-assured, confident, but he was doing all this stuff (drink and drugs) which I didn't know about. [She feels betrayed, let down, confused].
BreA p8 – I thought (after birthday meal) I don't want to be seen with him. [realistic pessimism?].
BreA p12 – I thought well, it would be a you know one, two or three meetings at most and then he won't go [pessimistic prediction].
BreA p12 – But I see it now (his journey from AA start) I mean as I told you this is 5 years hence since he had a drink, but he's gone to the other extreme. [Title for B – "he's gone to the other extreme" – she is not happy now he's stopped drinking].

DiaA p6 – So it's the usual thing (always drunk when I phone) then you end up dreading making a phone call because you don't look forward to it, then because you know, oh God I've got to be there, you know, "it's all right". [Pessimistic expectations for phone calls, but realistic. That's perhaps one of the most difficult aspects of drinkers – the alcohol fuels difficult behaviour and reduces hope/optimism for a quality conversation?].
DiaA p6 – At the time (of the help me call) that (counselling) was what we were doing (even though I know it's pointless when someone is taking that much cocaine and drinking).
Incomprehension - BreA p9 – I thought how could he behave in such a way (lock-out).
Incomprehension - Lorap6/7. Sometimes I'd look at him and think what am doing? [Asked – any particular incident spring to mind?] No, it was just most of the time.

[ii] The Positive: Optimism, Praise for the Drinker, Positive Reappraisal …

POSITIVE REAPP (LinAp4) "It's (Don's drinking) taken its toll" (mentally and physically) and I've learnt a lot from it.

PRAISE FOR DRINKER (BeraP9 I'm amazed at how well he's coped" (4 weeks after stopping drinking).
PRAISE FOR DRINKER BeraP10 [Amazed with him stopping (after my reflection about it taking a lot of strength and commitment to cut down (himself before Christmas).
BeraP10 [Proud of him] Proud as she told me he hadn't had a drink for 3 weeks. PRAISE?

PRAISE BeraP10 Well you didn't you – in response to Roger saying he felt he could have had a drink when he heard that his daughter was having problems, with her mother (his ex-wife).
PRAISE BeraP11 B showed pride in Roger staying off the drink even though he had the stress of not having a job [empathy for him].

PRAISE BeraP18 Beryl said, "you're really doing really, really well you know and I praised him for putting in a lot of thought and effort into reducing his drinking before Christmas.
PRAISE (gratitude) peaAp6 [I think] he was very frightened himself (when she had cancer) but really looked after me. [It is obvious that Pl views C as making her happiness and well-being a priority even at the 'expense' of not telling her how frightened he was]
PRAISE for DRINKER - Judap4. And what I do now (he's stopped drinking) about him is to give him lots of praise about him, say it's great cos he still has friends who like a drink and its affected his social world. [Child-like theme].
PRAISE - Judap9. I think that one of the thing that 'saved' him was the children, he loves them, he wants them to do well, and his drinking wasn't good for <u>them</u>.
POSITIVE INTERVENTION from ME peaAp13 [Me- absolutely hindsight's a remarkable thing – after P telling me she just behaved as she behaved] – yes isn't it just, isn't it just.
OPTIMISM (for him)? BeraP13 I'll be surprised if he does (drink) because we're 4 weeks this week".
BreA p6 [Thinking 'good' in the past Optimism past] [Co what made you think you were being used?] – I'm just thinking [present tense] yes we had [past tense] a good relationship.
OPTIMISM - DiaA p8 – (When E said well at least we've got water when I was stressing about the heating packing up) I thought, oh bless him, bless him, he said to me what I would have said to someone, you know, perhaps not quite like that but he's very good at comforting people and just hearing that from your 15 year old son.
OPTIMISM - DiaA p9 – I thought he'd just put it (glass of champagne that was just handed to him) on the table or something and it would be OK. I thought well he'd got to take it really otherwise it would just get to be a big thing. [she was disappointed]

[iii] Insight was initially a Positive Theme – Became part of the Meta-Theme.

INSIGHT BeraP11 Beryl realises R can't be a social drinker anymore.

INSIGHT - Lorap4. They say that they reach rock bottom, something in there, (in his head) just thought I can't go on like this.
INSIGHT - Lorap4. [Me – can you remember how you thought about it when you were in your teens (re how was it different to your realisation that you weren't responsible for G's attempting suicide etc)]. I think that when you're a teenager you think differently about things.

Partners' Responses – starting to sort

[Originally to drinker not drinking but then became more general. Needs to divided into responses to drinking and non-drinking.]
LinAp? [She hardly drinks –easy – stronger than him?] Linda hardly drinks at all now (and even before, when Don was drinking) she felt that she knew her limits/when to stop and have a soft drink (because she knew when it was affecting her). Linda claims <u>she</u> doesn't come from a drinking family.
BeraP11 [Stopped drinking at home] I haven't drunk and won't drink at home because I don't want him to drink (she was drinking before, although not heavily).

Lorap4. I stopped drinking when Graham stopped drinking.
peaAp7 [Noticed change in his character – after fight] I noticed that Chris changed completely (from the day of the fight) he went from being very outgoing to being totally on his own.
peaAp8 [Empathy with him] I say – he must have felt so ashamed [after fight] – Pearl agrees.

peaAp15 [Compassion for him – re not rushing him out] Yes (I can give you a couple of days to find somewhere) that fine, there's no rush..
peaAp9. [Accepts his criticism, therefore similar to negative self-criticism?] Chris always says I find it difficult to talk about my feelings which I certainly used to [before Al-anon]
INSIGHT ? ACCEPTANCE? peaAp9. What's in a name...is he an alcoholic? [surprisingly I think this might be an important code because it demonstrates the triviality of a diagnosis of alcoholism to the actual day-to-day reality of the situation].
peaAp15 [Consideration for him – even after betrayal] I made him a sandwich (before I planned to go to Elaine's)

NEGATIVE peaAp15 Well she had done anyway (got in the way)
peaAp17 [Thinks he's been difficult with other woman] I think he'd been so difficult with her (deliberately or not I don't know) but she'd kicked him out.

peaAp17 [Let him stay] I said yes (he could stay the night because she'd kicked him out)
peaAp19 [Mixed feelings?] I don't know in the future I might go down the divorce road although she said she wouldn't

breAp4 [??] But of course its chicken and egg, which comes first isn't it (drinking and no money)
BreA p10 – I thought well he's being sort of dramatic (on the lead up to talking about his new business).
BreA p11 – I didn't say a word about AA, I mean those, those events (call girls etc.) had what you call nothing to do with drink had they? (I said no, not really, not specifically).
Judap1. I think he would think, oh that alright, it's part of my social world. [This is how he dismisses her concerns about his drinking]
Judap2. I think the realisation (that his drinking was causing problems) for him was very sad.

Lorap3. When he came back (from Menorca) I thought that was going to be the point, I always thought there'd be a point when he'd say I'm going to do something about this now and I thought that was going to be it and it wasn't. [Optimism / hope then disappointment]
Lorap8. I'd have liked it if he'd have gone.
LorrA p13 – [Me – You keep things contained (and don't let them keep resurfacing) don't you?]. I probably get that from my parents, my Dad especially.
DiaA p4 – So I kind of empathised with Andy (because she knew he had been rejected by his wife although he didn't yet).

Telling him / confronting the behaviour (behaviour)
LinAp? [Telling him TO] I kept telling Don to be careful how much he was drinking.
LinAp? [Telling him NOT] here were moments when I would have to tell him off".
LinAp? [Got cross – money and shirking responsibility] Got cross when Don was running up bills on credit cards – "Who's going to pay for this…you're not working" – i.e. shirking responsibility.

LinAp? [Provoke him into stopping – make him see I mean business] Got estate agent in for price – Linda threatened – "I'll sell and you go your way and I'll go mine…if that's what you want" – "I was doing it really to try and shake him…to make him realise I mean business…I'm not putting up with this

Affection / Love for Partner

Linap? C's really the gardener, I just do the weeding

BeraP20/"He is in a sober place and it's nice to think that he is".

peaap5. Chris was absolutely wonderful during all the time [when I had breast cancer] he was absolutely fantastic.

peaap6. "He was just extraordinary, just extraordinary". – "just looking after me, nothing was too much trouble

Lorap8. Things you see (like he's good with people) when I saw him drinking, they haven't changed [this is saying that even when he was drinking she could see positive aspects to his character expressing themselves]

FraA - And this is one of the things I admire about him, that he would choose to stay there [she values people who show strength and ability or willingness to help themselves, which the opposite is true when people are alcoholics – she despises weakness]

FraA -He noticed the garden was in a mess and he got permission for me to bring him some tools, so he could start clearing up the garden round there and this was someone, who, two weeks was completely out of it.

FraA - As far as I'm aware, he's not had a drink and do you know I don't think I remember him, since he came out of that place, having any withdrawal symptoms [sounding amazed].

FraA - I was only in my early 30's and I think, you do think you can do it and it will work out and we were *both* desperately in love, it was not, it was not a flash in the pan.

FraA – My daughter Is proud of him, she says she's proud of him and I am, in a way [quick almost after thought].

FraA - I've always felt supported, I've always felt that he valued what I've brought.

FraA - Cl I think he's done amazingly well. (Co. Yeah)

LynA - Cos he's a really lovely, he's a really lovely caring, a beautiful caring bloke.

LynA – (And he would get, what I would call belligerent and he's not belligerent he's not), he's a really kind, lovely, gentle man.

Some Thoughts Along the Way

"Partner's Responses" – This needs to be sub-divided into for example: responses to drinkers, responses to life's situations, emotional responses, thoughts as responses, responses to conversations, responses to me, to other people etc.

Noticed proactive and passive responses. / Links with Dweck and Leggett's work on attributions about the nature of intelligence i.e. if intelligence (or the drink problem in this case) is seen as fixed and immoveable then it is sensible / appropriate to give up trying to change things etc.

Someone like Heather generated a relatively large number of extracts for the "Biography", whereas Christine generated very little – I need to think about such differences. It may be that C was 'skirting' around for quite a while and H wasn't?

2nd / 3rd Level – Summarise / reduce size and complexity of the code.

Themes move from superficial to deeper, Don recognised this.

Rom Harre (1998) "The Singular Self"

p.ix ‘Person’ seems to me the most robust notion in a sea of uncertainty (re conceptualisation of self). But this notion is itself internally complex, in that it picks out beings who are both materially embodied and enmeshed in networks of symbolic exchanges, which are, at least in part, constitutive of what they are …. I come to the conclusion that psychologists must accept not only that their ‘science’ is built on a dual ontology, molecules on the one hand and persons on the other, but that it requires two radically different methodologies. It soon became clear that, for the most part, selves are fictitious. By that I mean that certain features of the flow of activity produced by persons in interaction with another are picked out in ways of speaking and writing as entities, as if they had an existence of their own. However, it may be that there is no better way of talking about certain common features of human interaction than some form of ‘self’ talk.

P.2 No two people are alike, yet all bear resemblances to one another. There individuality just being a different thing from other things. But there is also uniqueness being like no other thing … in the human world, it is uniqueness. Personal singularity, that is the leitmotif of all our forms of life. … Each unique human being is a complicated patchwork of ever-changing personal attributes and relations.

[General thoughts on Harre’s perspective – Discursive psychology can be employed to capture some of the singularity, uniqueness of a person (through ‘line of life’) by studying ‘points of action’ (from line of life) in conjunction with their points of view (includes attributions of causality). So I am looking for focused, selective ‘points of view’ from my participant’s narratives?]

Look at the words people use to describe positive and negative experiences – e.g. the word “horrendous” seems popular – does this link with the dominance (plus greater predictive power) of negative / bad events.

I’m getting evidence (especially from G) of a ‘root’ / dispositional optimism – it is a general guiding force that seems to infuse – reminds me of the “Hallo Effect”. Also links to self-fulfilling prophecy – i.e. good things are more likely to happen if you have optimism / motivation to get out and do things and to have confidence to try (reminds me of the opposite i.e. depression where people recoil from engagement because of negative predictions, apathy, low mood, becomes a negative vicious circle).

Reflection – I am not a practicing Christian and this influences my feelings about Al-Anon.

Moving towards internal homogeneity and across theme distinctiveness.

Appendix 4

List of early Themes

The following list contains all the early themes that resulted from all ten interview transcripts. All entries for each theme were typed (originally hand written) and placed in separate files on my computer. The number of pages of each are included in (brackets). Themes in [brackets] were either subsumed elsewhere in later theming or did not feature in the final themes.

- General Biographical (26)
- Partner's response (56)
- [Negative in the positive (1)]
- Negative, emotions, thoughts, pessimism, lack of hope (25)
- Positive, optimism, hope, looking forwards (15)
- [Incomprehension (4)]
- Drinker's life without drink (9)
- Positive in the negative (4)
- Noticing the problem (46)
- Strength (3)
- Lay theories (3)
- [Partners influence on drinker (1)]
- Custom / Habit / Culture (2)
- Praise / love for the drinker (5)
- [Drinker's personality (5)]
- Stereotypes (2)
- [Change (1)]
- [Justifying behaviour (2)]
- Counselling (6)
- [Conceding to (drinker) partner (2)]
- AA for drinker (3)
- Support / Influence of Al-Anon (5)
- [Using new perspectives (1)]
- Role of children (2)
- Coping / Not (9)
- [Making excuses (4)]
- Denial / Not doing what you know you should (2)

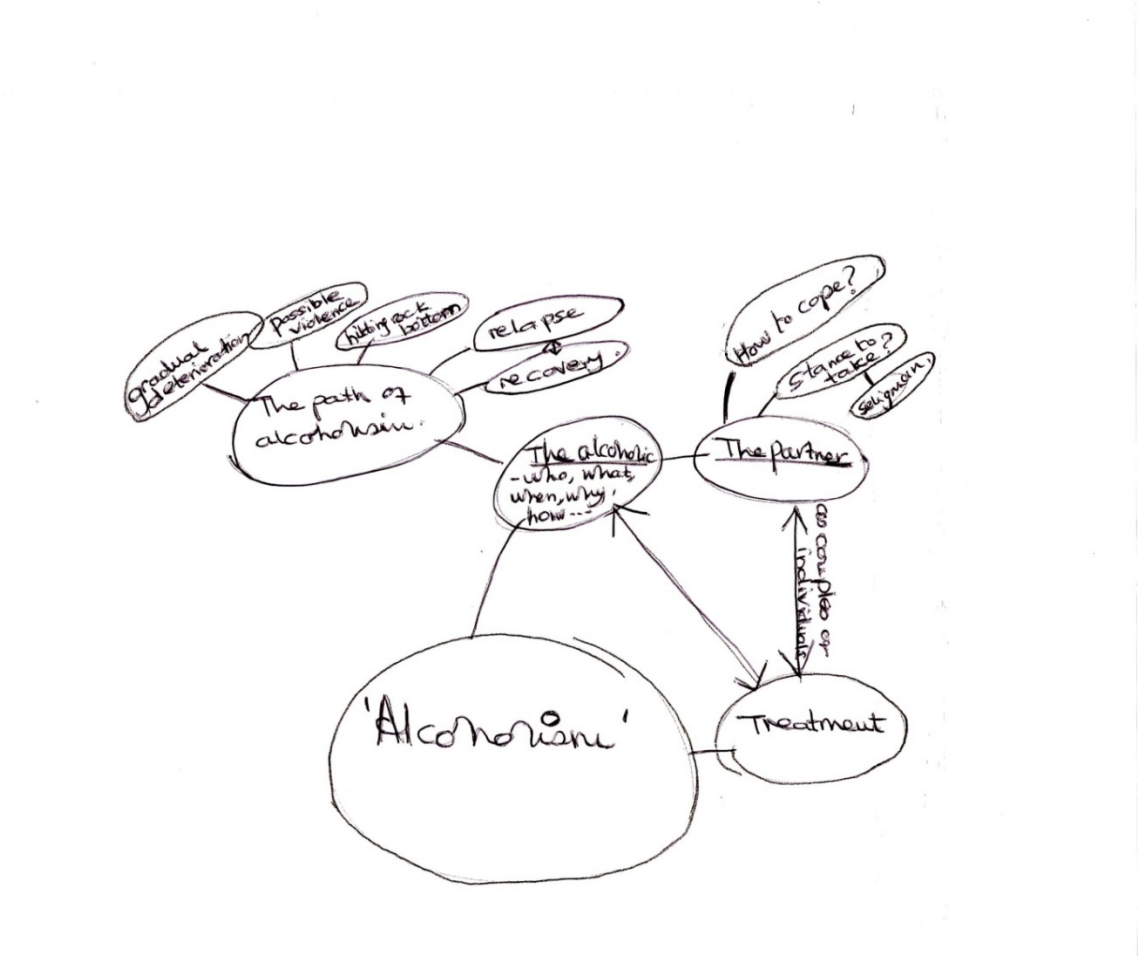
- [Why do I stay? (1)]
- Humour (1)
- [Looking for reassurance (2)]
- Insight (10)
- Resignation / Acceptance (3)
- Positive intervention from me (3)
- Relapse (3)
- [Value of talking / not keeping problem secret (1)

Appendix 5

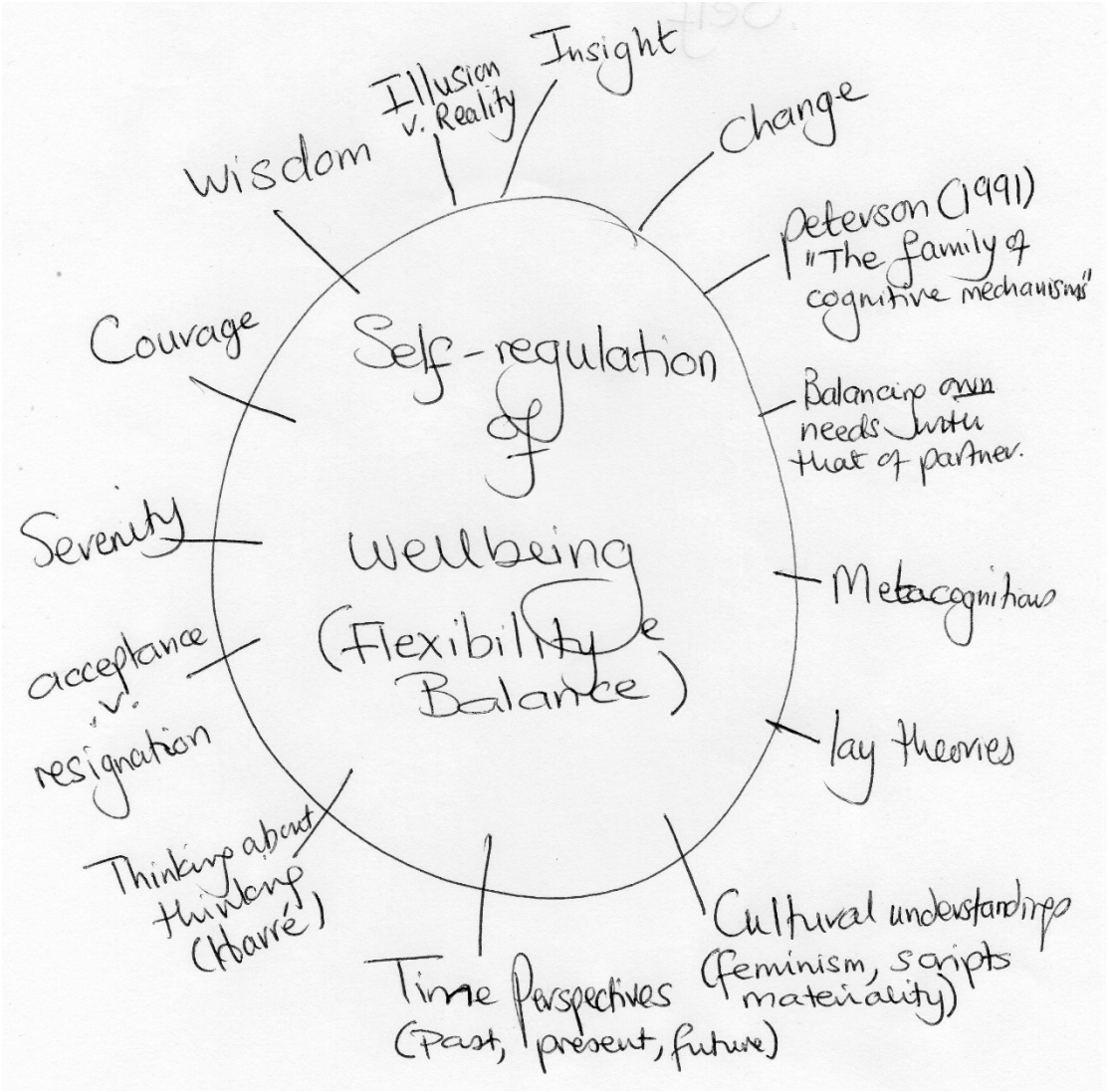
Early Theming Diagrams

The following diagrams show something of the fruits from this stage.

This diagram summarised my thoughts on the context of the drink problem as a complement to the women's perspective as it is partly 'driven' by practice considerations / literature.

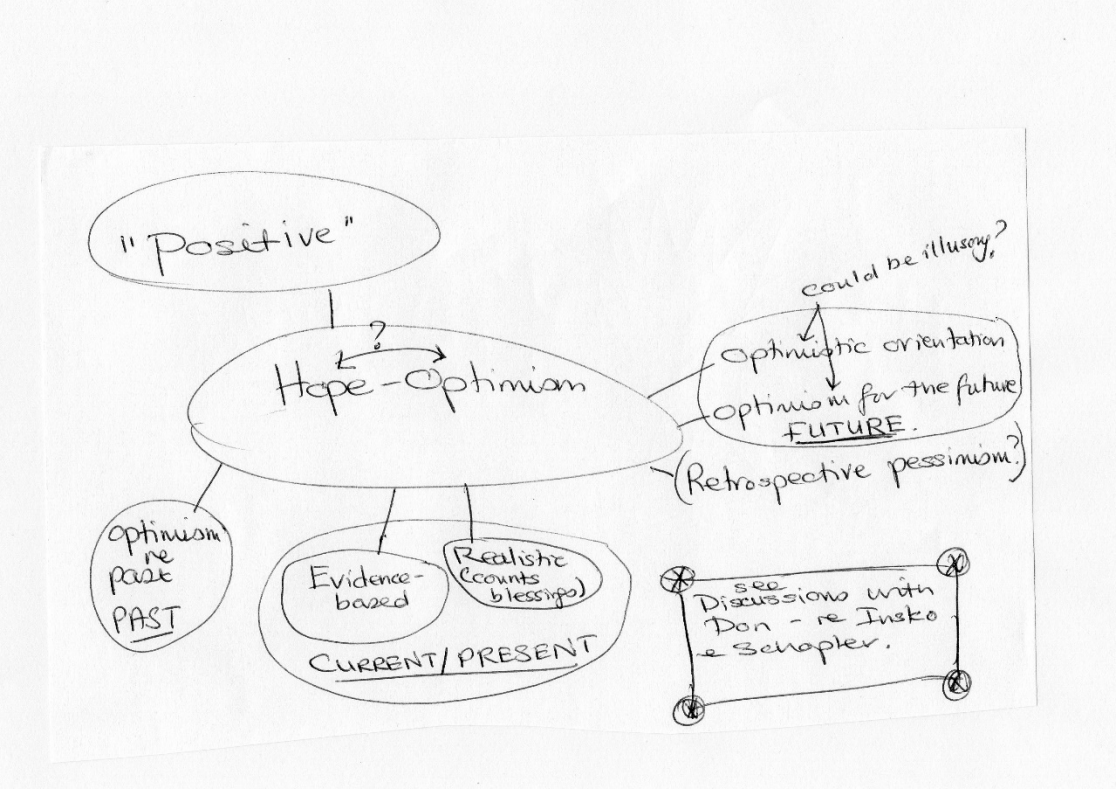


This diagram summarise my thoughts of the women's perspective in terms of balancing various (primarily cognitive) elements of wellbeing.

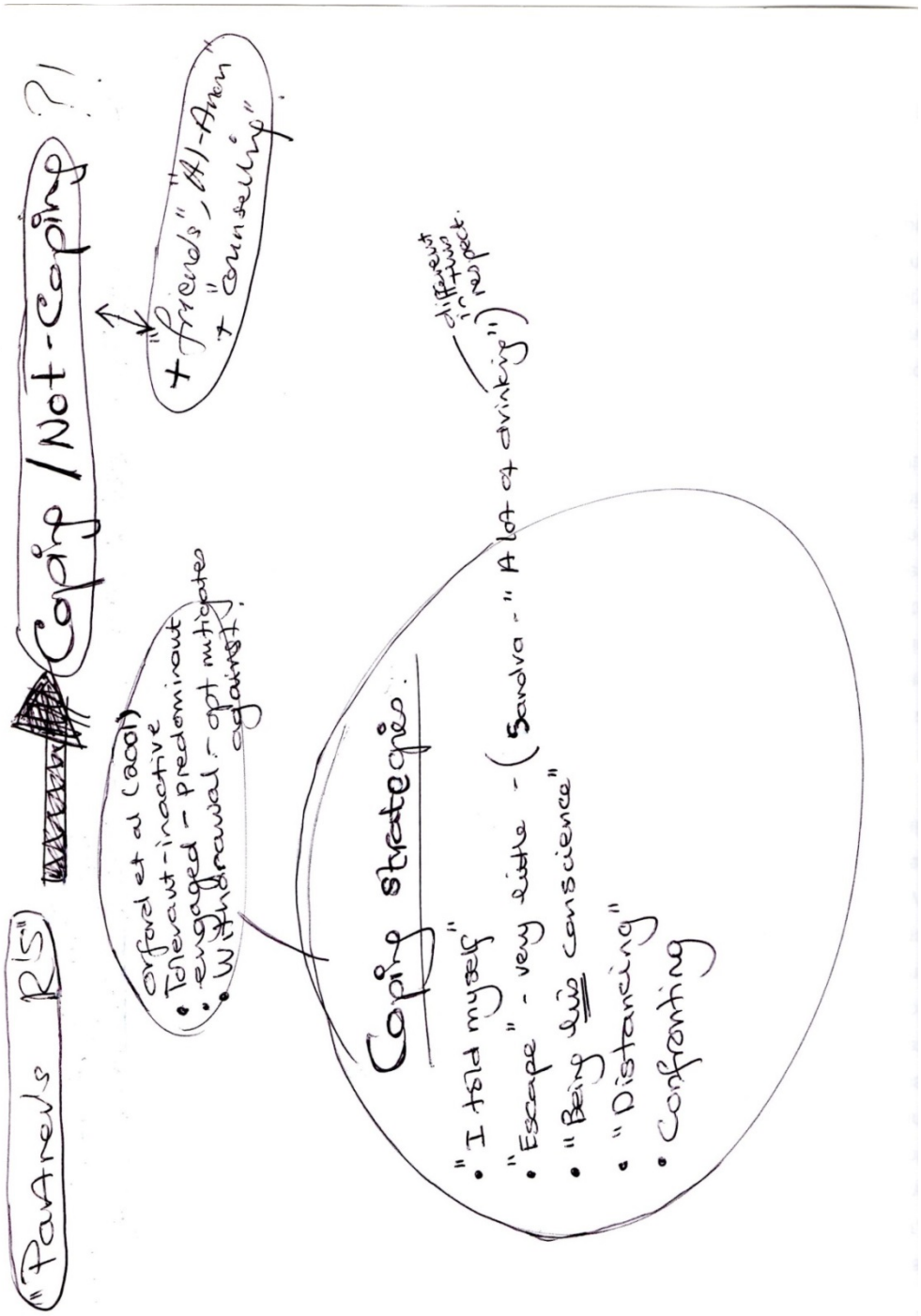


Focusing on the main ‘negative’ ingredients; trying to distinguish between commonality and individuality.

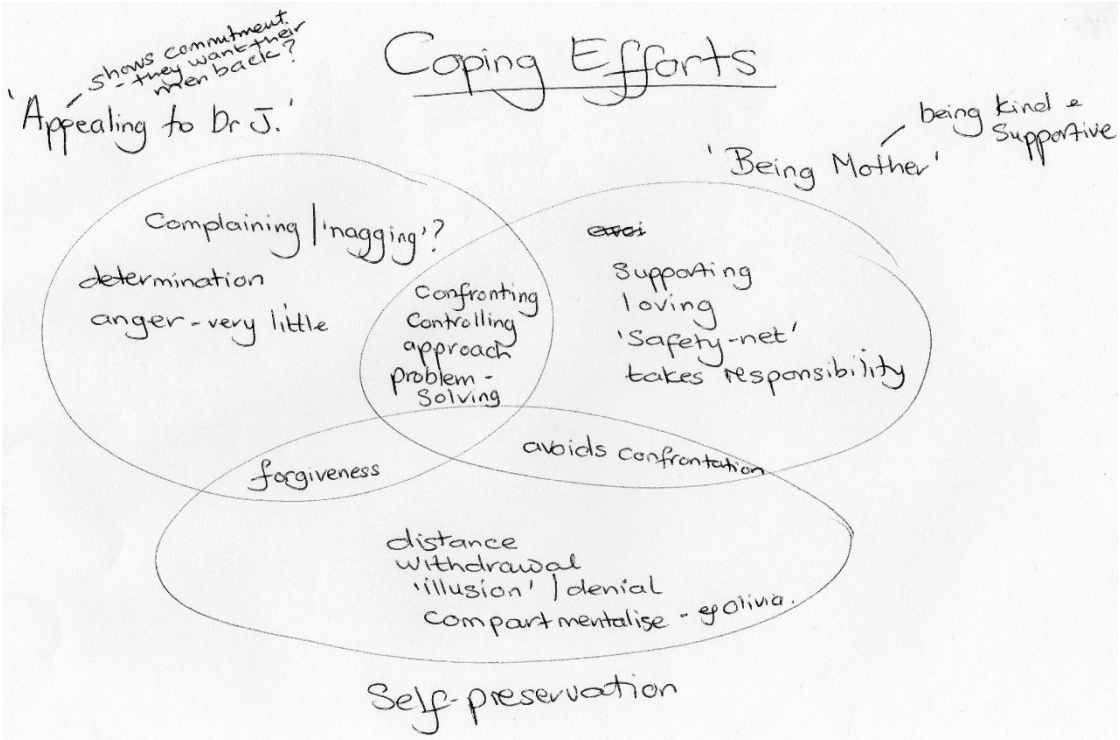
This diagram refers to my thoughts on the positive aspects and starting to link these with existing theory.



Focus on coping and not coping – decided not to have a theme entitled not coping as it implies failure which I didn't think was warranted (e.g. Orford's notions of coping which embrace trying things that don't work but all part of coping).

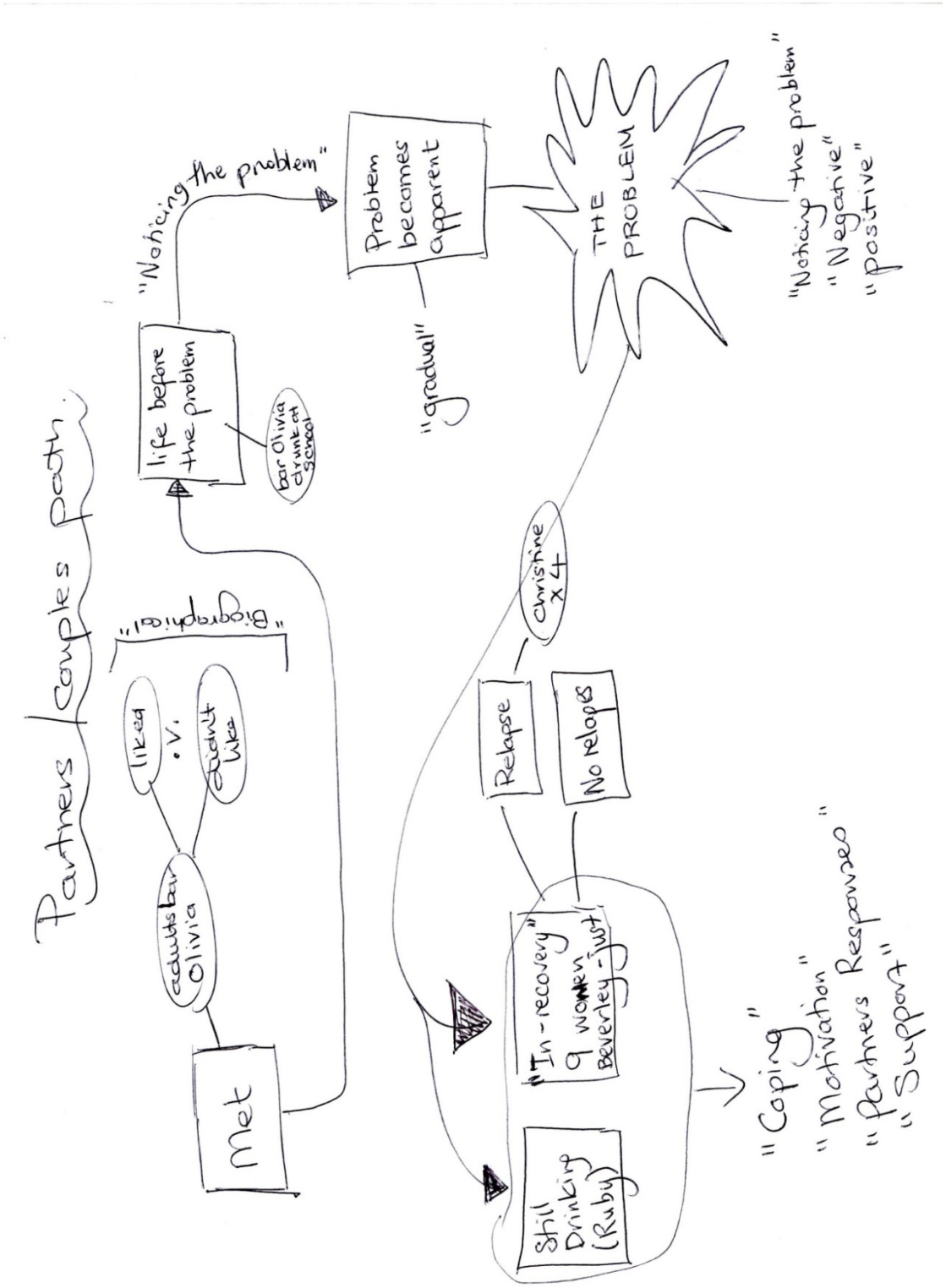


Later thoughts on coping with much more of an experiential feel – I was conscious of letting the transcripts rather than a priori knowledge be the driver. The three themes here ‘made it’ to the final stages and write up and I have tried to convey a sense of distinction but also overlap and complexity.

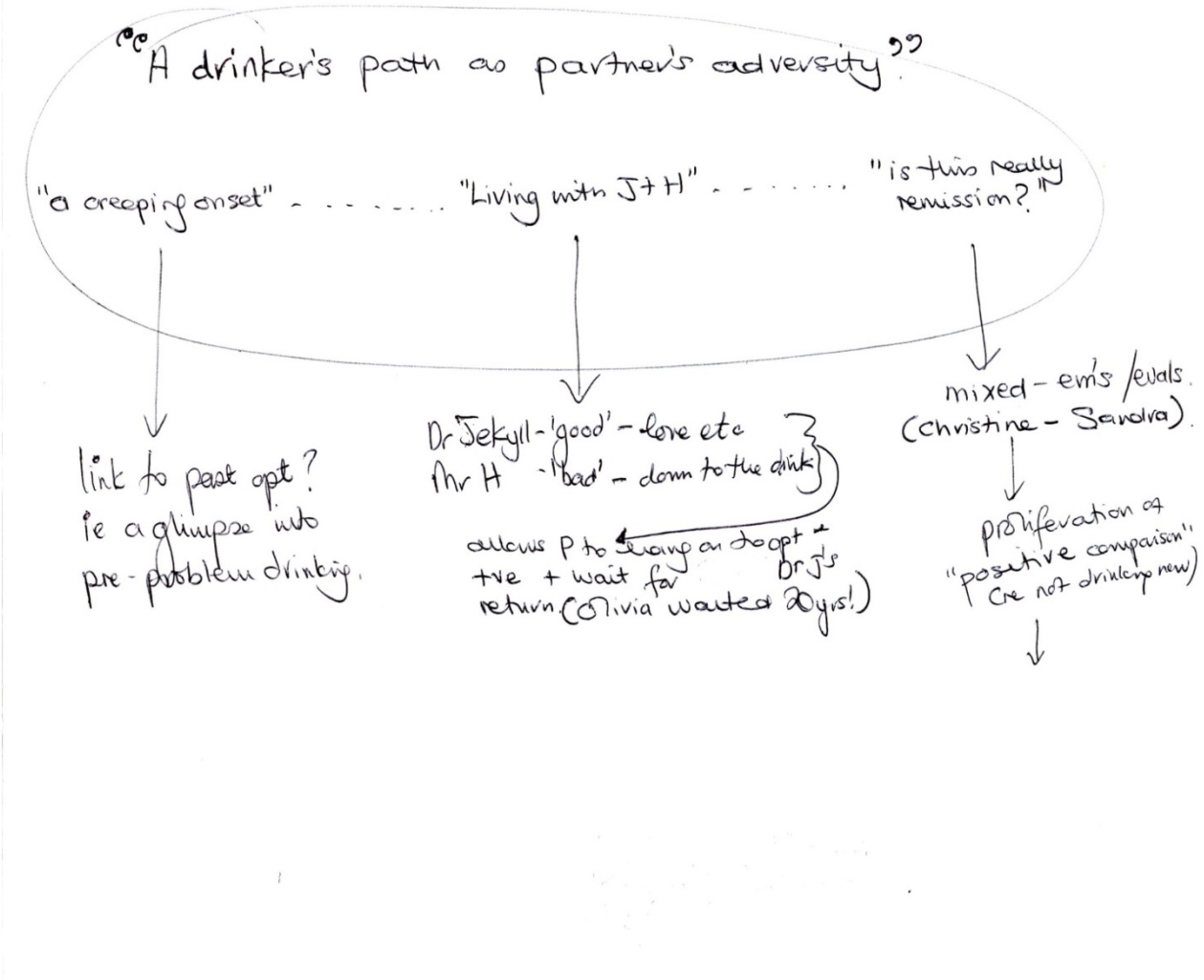


This diagram attempts to evidence my thoughts on the interrelatedness of the women's lived experience. Specifically the connections between optimism, pessimism, emotions, motivation, coping, self-discrepancies and various cultural influences.

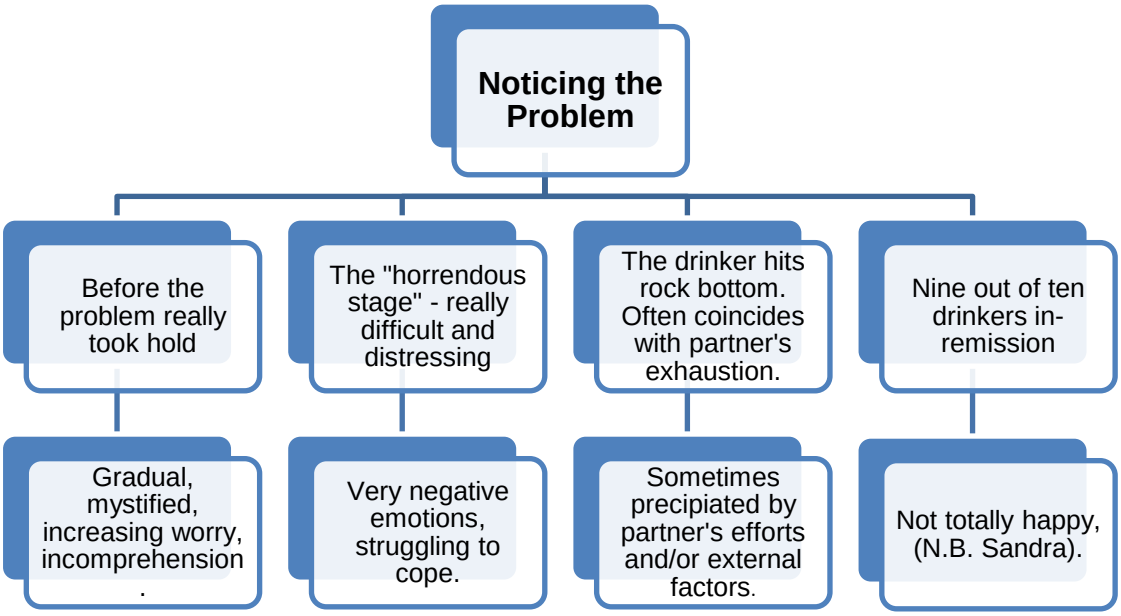
This diagram starts to elucidate what eventually becomes the context for all the themes, the ‘journey’. I am trying to organise my thoughts around what belongs to the individuals (particularly the women) and what ‘belongs’ to the problem / men and where these coincide.

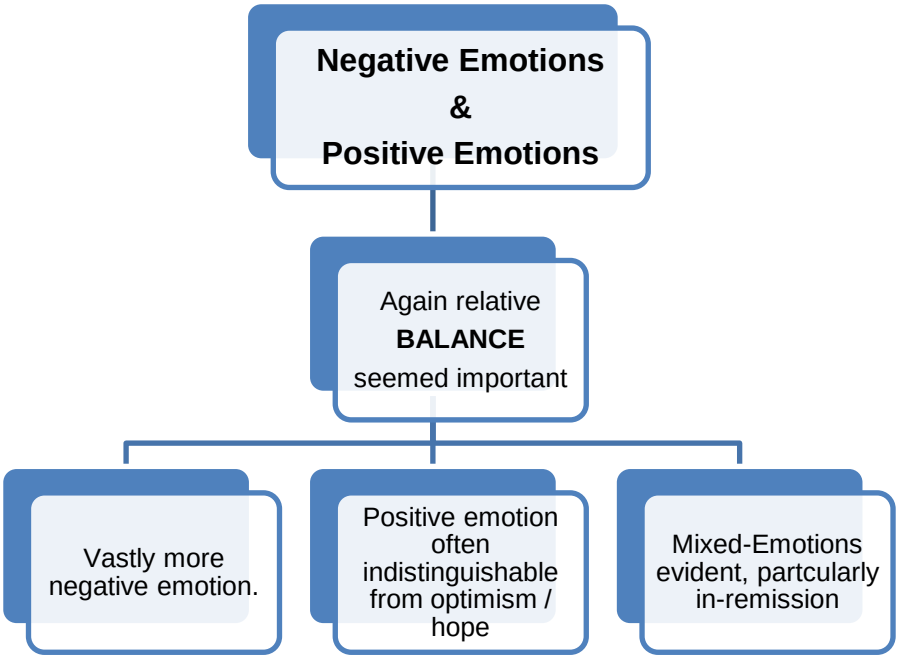


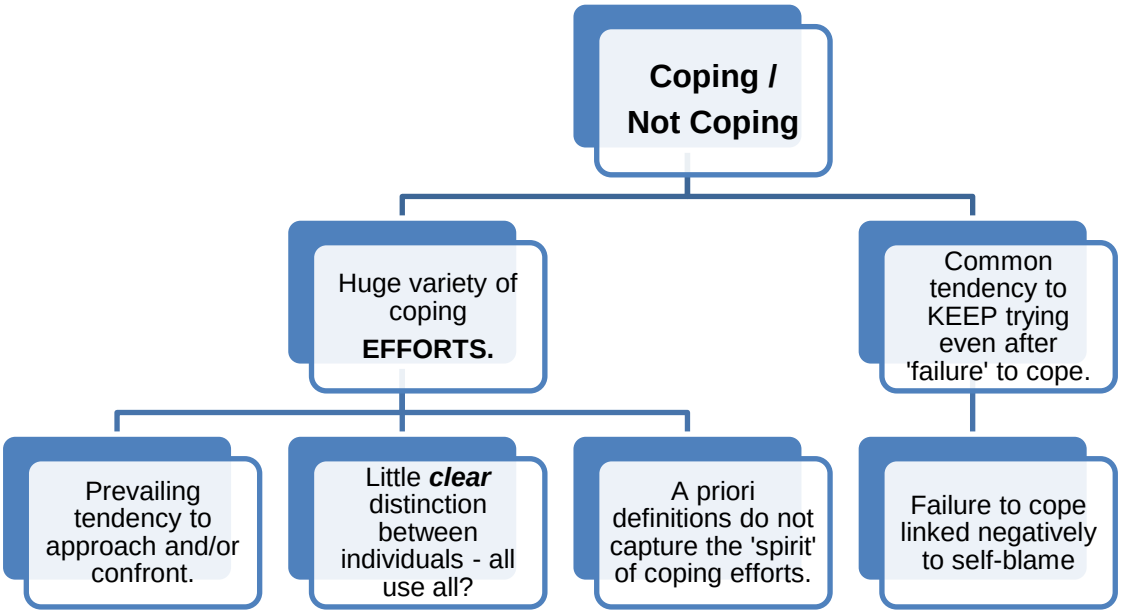
More early thoughts on the journey. The main differences to the later versions are: Only the term ‘adversity’ is present – some time later I realised that I had made an erroneous assumption that the impact on the women was ‘all bad’. Later readings and reflections lead me to include ‘challenge’, therefore allowing ‘growth’ and benefit. ‘Is this really remission’ becomes the last two superordinate themes (‘dry’).

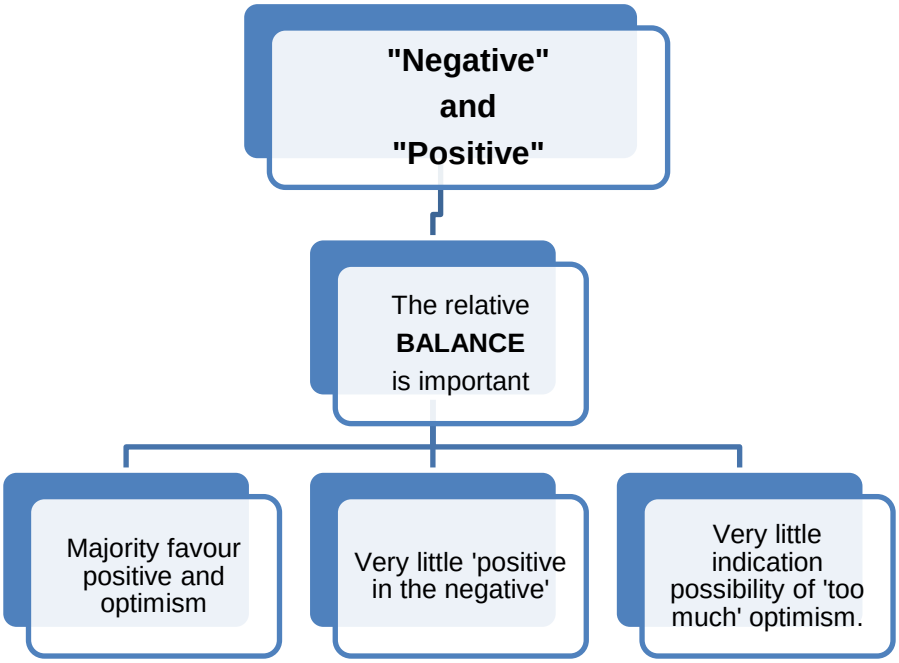


The following two pages show some early efforts to gain clarity on major themes. The notion of BALANCE became important.


Noticing the Problem
Before the problem really took hold
The "horrendous stage" - really difficult and distressing
The drinker hits rock bottom. Often coincides with partner's exhaustion.
Nine out of ten drinkers in-remission
Gradual, mystified, increasing worry, incomprehension .
Very negative emotions, struggling to cope.
Sometimes precipiated by partner's efforts and/or external factors.
Not totally happy, (N.B. Sandra).

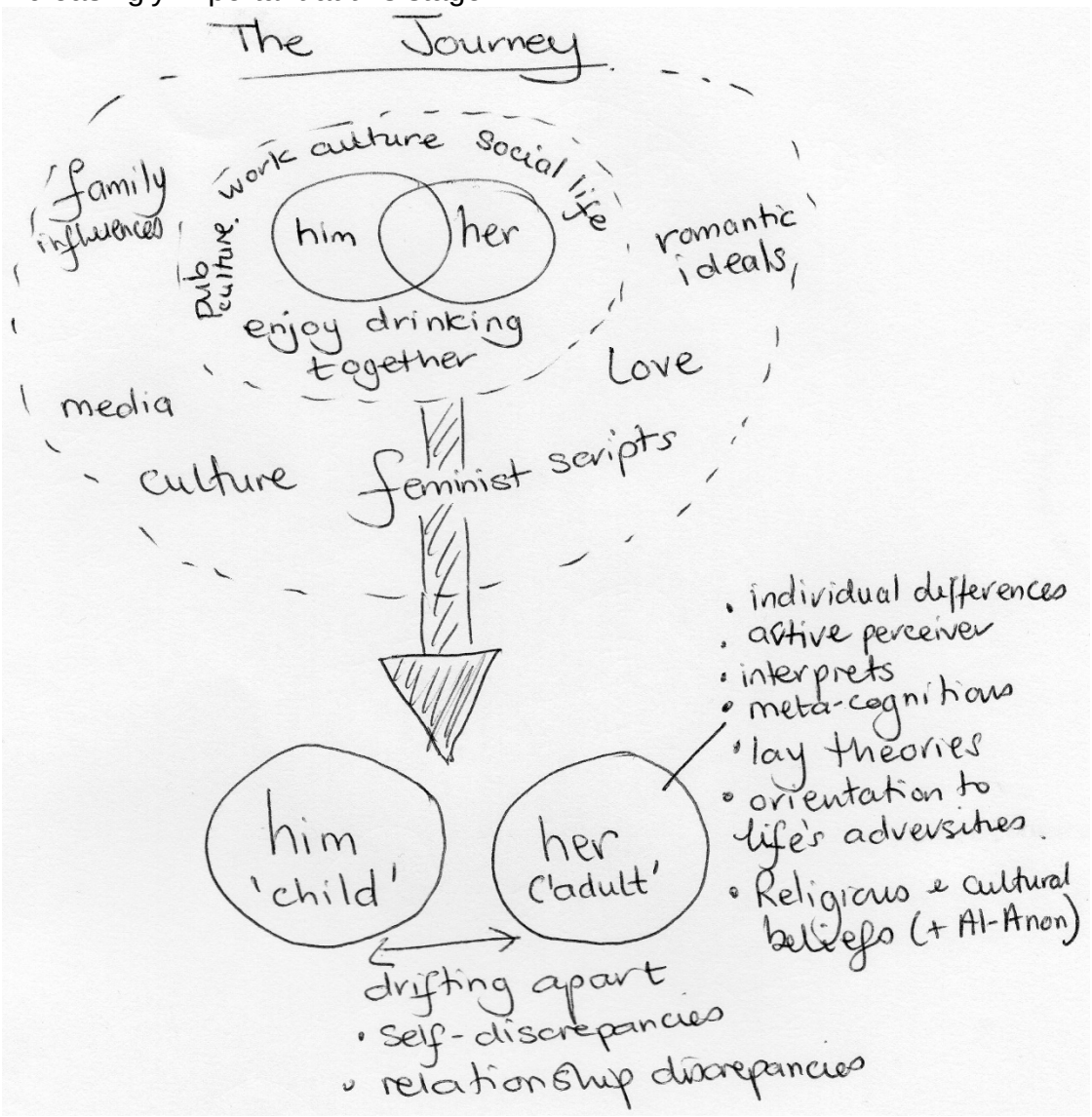

Negative Emotions & Positive Emotions
Again relative BALANCE seemed important
Vastly more negative emotion.
Positive emotion often indistinguishable from optimism / hope
Mixed-Emotions evident, partcularly in-remission


Coping / Not Coping
Huge variety of coping EFFORTS.
Common tendency to KEEP trying even after 'failure' to cope.
Prevailing tendency to approach and/or confront.
Little *clear* distinction between individuals - all use all?
A priori definitions do not capture the 'spirit' of coping efforts.
Failure to cope linked negatively to self-blame

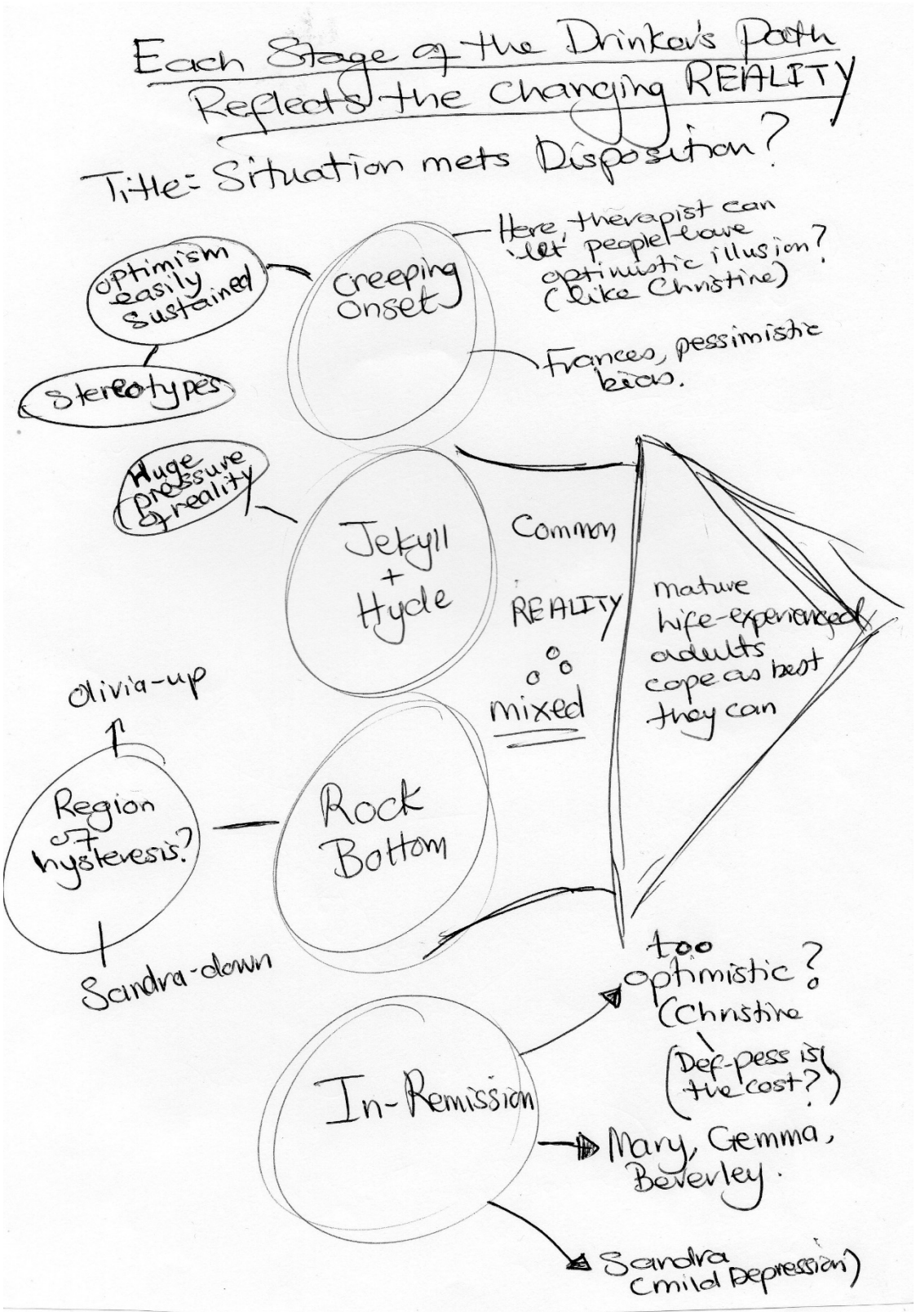

"Negative" and "Positive"
The relative BALANCE is important
Majority favour positive and optimism
Very little 'positive in the negative'
Very little indication possibility of 'too much' optimism.

Appendix 8
Later diagrams – THE JOURNEY

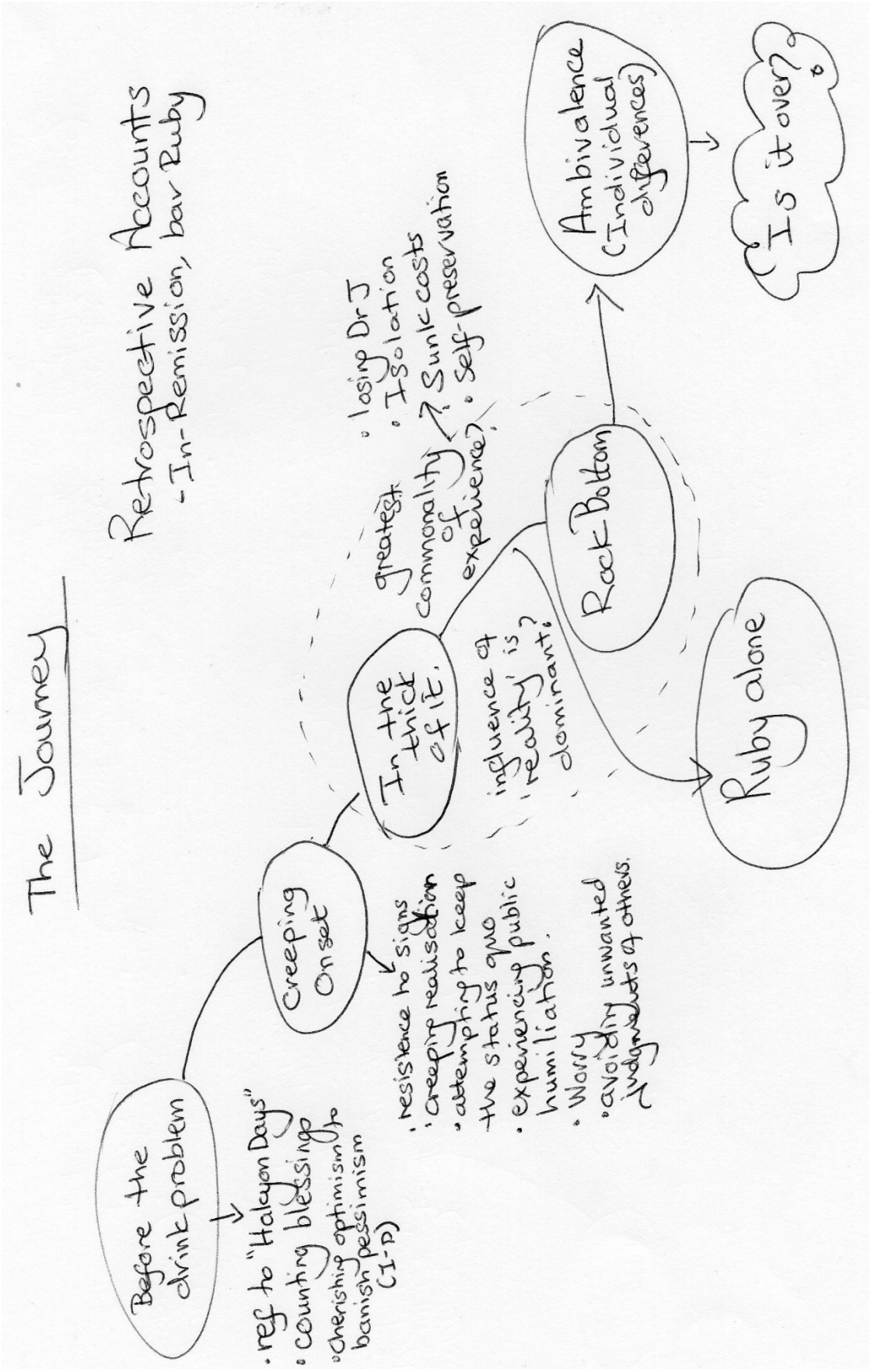
The following diagrams are much closer to the finished research as they try to draw my interpretations together with the literature. The RELATIONSHIP becomes increasingly important at this stage.



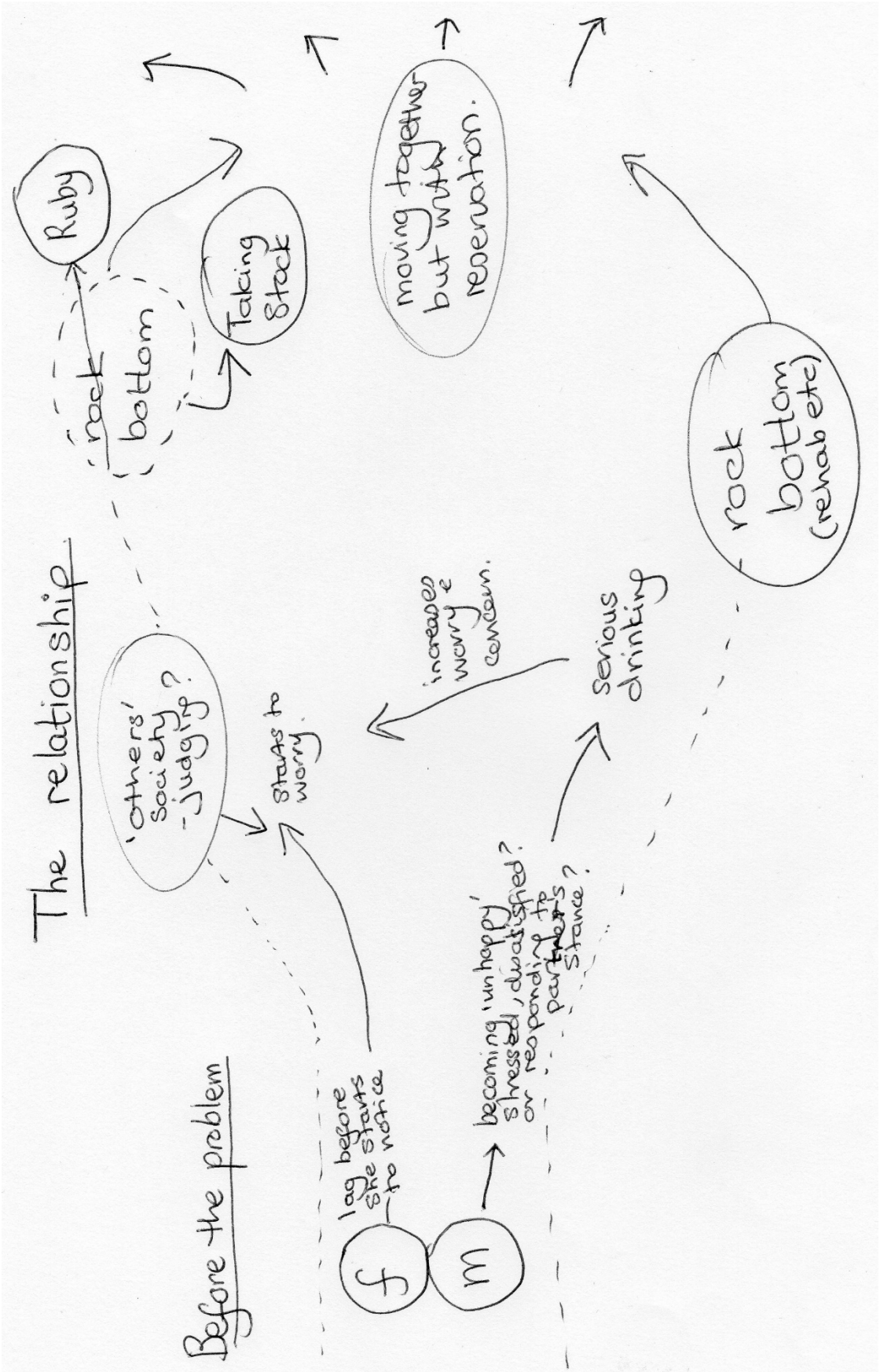
Trying to 'blend' 'reality' and individual differences.



This diagram is close to the finished representations.

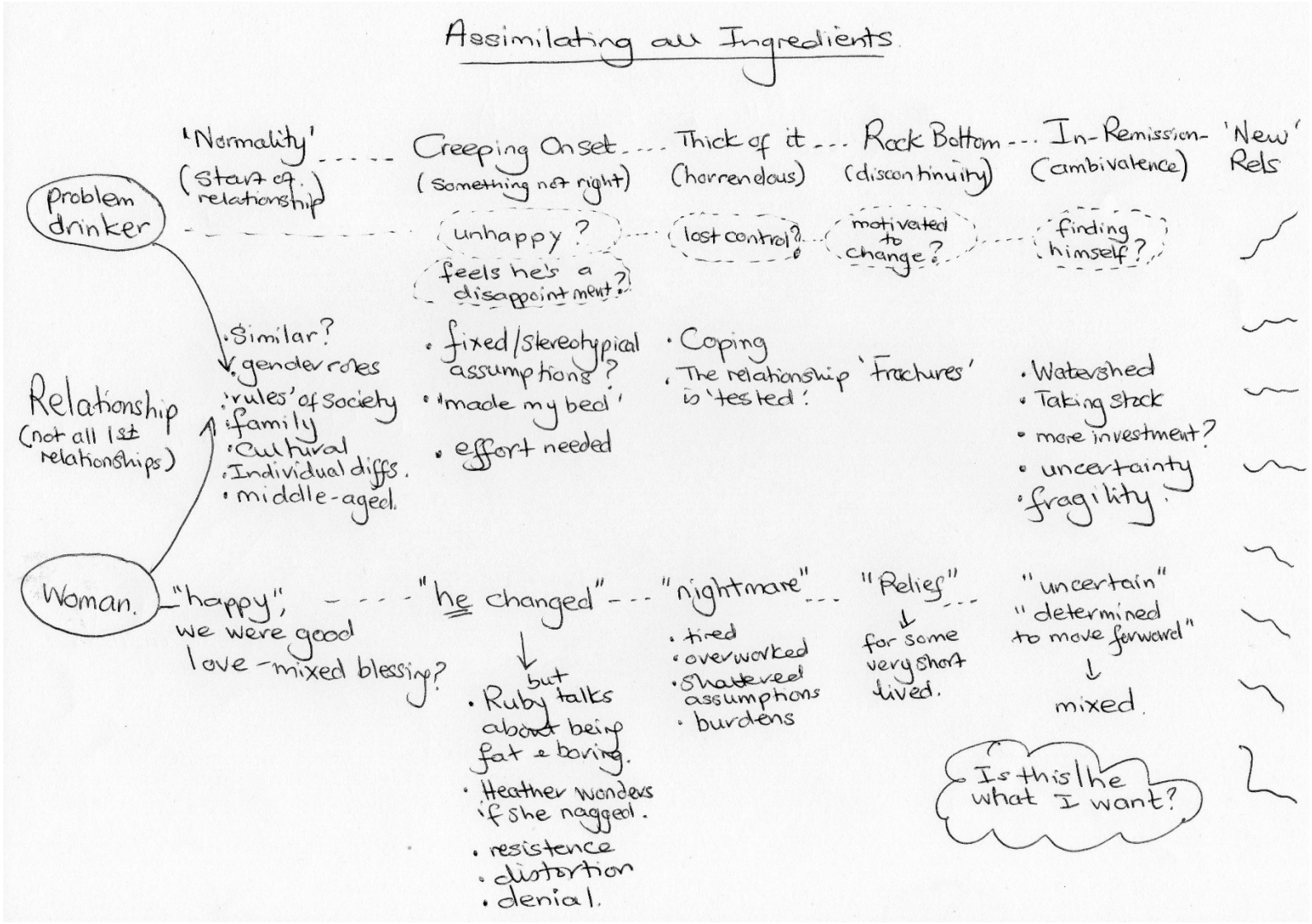


Considering the relationship within the journey.



This diagram helped me to clarify my thoughts about the women within the parameters of traditional approaches to working with PPDs.

This diagram similarly seeks to provide a schematic representation of the main features of the women's stories.


Assimilating all Ingredients
'Normality'
(Start of relationship)
Creeping Onset
(Something not right)
Thick of it
(horrendous)
Rock Bottom
(discontinuity)
In-Remission-
(ambivalence)
'New' Rels
problem drinker
unhappy?
feels he's a disappointment?
lost control?
motivated to change?
finding himself?
Relationship
(not all 1st relationships)
•Similar?
•gender roles
•'rules' of society
•family
•Cultural
•Individual diffs.
•middle-aged.
• fixed/stereotypical assumptions?
• 'made my bed'
• effort needed
• Coping
• The relationship 'fractures' is 'tested'.
• Watershed
• Taking stock
• more investment?
• uncertainty
• fragility.
Woman.
"happy", we were good
love - mixed blessing?
"he changed"
but
• Ruby talks about being fat & boring.
• Heather wonders if she nagged.
• resistence
• distortion
• denial.
"nightmare"
• tired
• overworked
• Shattered assumptions
• burdens
"Relief"
for some very short lived.
"uncertain"
"determined to move forward"
mixed.
Is this/he what I want?

Appendix 9

Reflexivity / Exemplar Table

The following table attempts to show many of the considerations and decisions that lead me to the finished research component. In other words these were founded in the earlier work but included much more of my interpretation of the participant's interpretations (double hermeneutical work). They were also predicated on the notion of a journey in which to embed the six resultant superordinate themes.

Exemplar of Transcript, Theme, Issue	**Dilemmas, Decisions, Resolution**
Overarching Title: ***The Drinker's path as Partner's adversity and Challenge.***	My early theming showed evidence of a retrospective narrative of a chronological journey. This significance of this journey was not clearly evident until the 'mid-stages' / after early theming was reviewed. Themes such as 'noticing the problem', 'the problem', 'rock-bottom, 'rehab'/AA/Al-Anon. This title was adopted as the eventual title for all the resulting themes which were 'placed' at appropriate 'locations'. Some themes spanned more than one location, like 'worry', 'sunk costs', 'considering responsibility, but this was noted as appropriate. Also important to note that the journey title allow both 'positive' and 'negative' lived-experience to be an important aspect of balance and interplay.
Superordinate Theme One*: Before the Drink Problem*	
I saw his weakness [alcoholism], unforgiveable weakness [as a] complete failure of the relationship. [Fay] knows this is *"not orthodox"*	This type of extract was mainly used in the theme 'considering causes' where Fay was noticeable in her bold use of the term alcoholism. I also saw it as part of Fay's fairly individual (or as she says, "not orthodox") approach to most issues and stages. She seems to have very sharp and clear insight into her own strong beliefs and values and describes herself as "quite feisty" (a description that matched my own).

Superordinate Theme Two: *A Creeping Onset*	
I felt embarrassed when he fell asleep at a friend's dinner party *because I just thought he was tired and really what he drank was peanuts* [Christine] Embarrassment and or Shame? My early impressions (or perhaps assumptions) were that shame would feature more highly than is apparent from the women's narratives. Embarrassment however was distinct and visible in the majority of accounts and explicitly stated on most occasions. In other words, embarrassment was a very manifest theme and my interpretation gradually evolved into the theme – *'being the social conscience'* as this was where the embarrassment seemed to stem from.	Focusing on embarrassment rather than shame resonated with Willig (2012) terms 'manifest' interpretation in that most extracts explicitly refer to "embarrassment", which I interpreted as stemming from the women's anxiety as the 'social conscience' for the couple. Similarly I gained very little explicit (or even implicit) sense of shame (although Christine was an exception in other extracts, not the one shown here). Consequently I understood that shame held little salience for these women. Further the apparent absence of this negative emotion was interpreted as appropriate, congruent, emotional responses to potentially pleasant occasions made unpleasant by their partner. In the later stages of analysis I explored the literature on shame and embarrassment (e.g. Van Vliet (2008, 2009) / Dryden, 1997, 2009) in order to gain a theoretical stance / definition / conceptualization – this lead me to support my earlier view that it was appropriate to focus on embarrassment.
I felt embarrassed when he fell asleep at a friend's dinner party because ***I just thought he was tired and really what he drank was peanuts*** [Christine]	This was an interesting extract and for me highlighted a number of issues / thoughts. I wondered whether it was denial or did Christine really mean that Colin only drank a small amount – this links to the linguistic elements such as metaphor and similes which I am finding increasingly fascinated by (see Knowles and Moon, 2007). In any event such language strikes as very child-like. I wondered whether this was more to do with the potentially distressing nature of the forth coming narratives or more to do with Christine's personality and/or habitual / 'normal' language use. This extract could also been seen as a type of coping strategy –

	i.e. to lessen the impact or consideration of the problem. I eventually interpreted Christine's stance here as denial / protection – this decision was partly based on later explicit evidence *("I was in denial*"). Christine also seemed loathed to use terms such as alcoholic – seemed fearful of acknowledging 'harsh realities' (hence "peanuts"?).
Talk about men behaving badly [Sandra]	I considered using this extract as the name of a subtheme, but changed my mind as explained below. This extract is taken from Sandra's narrative where she is describing Simon's increasingly odd, erratic, and what Sandra sees as unruly behavior. Her tone of voice indicated that she knew she was being rather flippant when she said – "talk about men behaving badly' – almost as a joke but it wasn't a joke. I had the distinct impression, although I didn't check it, that she was referring to the TV programme "Men Behaving Badly". I decided that it might be construed as disrespectful / making light of something serious; although it was suitably accurate of what a number of women were 'really' saying.
"You see I was unhinged as well obviously" [Sandra]*;* which was *not* at all obvious to me.	This kind of extract make me feel sad and also precipitated a desire to be Sandra's counsellor (which I obviously resisted). I was sorry that she felt as if her sanity was in question, but just accepted this as one of the consequences of living with Simon as a problem drinker.
Superordinate Theme Three: *The Thick of It*	
In the very early days of themeing this theme was bar far the largest and called, 'noticing the problem'. It was then	The coping themes take up much of the space and analysis in this superordinate theme. In the early stages I was

subdivided into 'partners responses' / 'coping responses', the place of 'significant others' and 'emotions' / appraisals of 'happiness – unhappiness'; plus other more minor themes. Gradually, with further immersion, reading, familiarity, use of my subjectivity, these early themes were 'translated' into the five subthemes that are presented. Namely: 'Losing Dr Jekyll and living with Mr Hyde' / Three coping themes – (i) 'appealing to Dr Jekyll'; 'being mother'; 'self-preservation' / 'becoming isolated'. Specifically *'self-preservation'*.	conscious of being drawn into pre-existing conceptualizations of stress and coping (partly due to my previous research into stress and coping – transactional view, Folkman and Lazarus), but also by the importance of trying to cope as seen in the narratives. Such a priori knowledge and formulations were 'bracketed' during the early IPA stages. The discussion below acknowledges some of the later inclusion of existing knowledge and definitions. I acknowledged the theme 'self-preservation' almost as an 'antidote' to the many and various efforts expended on behalf on their partners, I came to sense their 'heavy heart' in taking time-out or even leaving for a period of time in some cases. Specifically I pondered the word 'disengaged' in relation to Orford and colleagues conceptualisation and the work of the co-dependency approach. I decided that the 'terms' engaged and by implication 'disengaged' almost 'clashed' (with prior work) or 'clouded the water' for me. I was particularly thinking in terms of the women's wellbeing where 'disengaged' felt too distant and perhaps disinterested in their partner? Similarly contemplating the descriptors 'withdrawal' (Orford et al. 1998a.b.c; 2001), 'detachment' (Kahler et al. 2003) and 'passive-avoidant' (Suls and Fletcher, 1985) seemed to deny the women's evident reluctance to 'leave' their partners, and the love and commitment that 'brought them back'. Eventually I decided that the title 'Self-preservation" was appropriate.
Still with coping: *Bad experiences at work* (*ran parallel in the very worst of my husband's alcoholism*) [Fay] Originally placed in early "Negative"	Fay's extract here reminded me of mainstream conceptualizations of stress and coping – specifically Holmes and Rahe's (1967) stimulus-response view, where stressful events accrue stressful consequences. These sorts of links to

theme, then "The Drinker's Path"	mainstream domains were made in Chapters Three and Four.
I thought I was getting paranoid at work … had the most awful bad luck [external cause for bad event (explanatory style) signals optimism?] … *serious problems in another job* [pessimism?] … (*but it turned out I was dead right*).	This extract seemed ambiguous but the "*I was dead right*" referred to Frances's 'discovery' that her manager *was* "*picking on*" her so named as "Insight" / "Congruence to reality" (early theme). In terms of the eventual presentation of findings and discussion, extracts such as these received little attention; they seemed to be moving away from the living with their partner domain, into much more individual personality realms.
An early small theme, 'Praise for the drinker', was subsumed under 'Losing Dr Jekyll'. I considered whether it could/should be subsumed in 'Halcyon Days' above.	'Praise for the drinker' was a small theme (but visible from the outset of the analysis) – I changed my mind a number of times as to where it best belonged. It felt right to subsume it into 'losing Dr Jekyll' as most of the extracts signalled loss and/or a wistful sense of past times.
Superordinate Theme Four: *Rock Bottom*	
Only subsumed one subtheme: *'Experiencing relief and positive emotion'.*	In some ways *'rock bottom'* was a very visible and important as it was a distinct discontinuity, in others ways it seemed quite 'hidden' and unknown. I distinguished just one subtheme, but as I explained in the portfolio, these actual, explicit reactions were only included by a few women, I reflected on this theme and wondered whether 'rock bottom' was seen as a bit of an anti-climax; it was important and great 'news' but I've just got to get on with the rest of life.
Superordinate Theme Five: *Resurfacing Reservedly*	
Three subthemes: *'Revisiting responsibility'; 'considering sunk costs'; 'strength through adversity'*.	The subthemes in Theme Five took significantly longer to 'evolve' and more checking back and across participants. In doing this I became aware that the strong

I gained a sense taking stock shortly after 'rock bottom', also a sense of 'lessons learned' through experience. This resonated with the notions of growing strength through adversity. The themes here though, like most of the others were tempered by individual differences.	sense of 'all being in the same boat' in the 'thick of it' had reduced significantly. It almost felt like the couples were gravitating back to 'normal' but that this was quite a fragile, unknown normality (apart from for Christine who had experienced this three times before – I discuss the possibility that Christine may be 'in danger' of being too optimistic). There is a strong sense of 'that was awful and I'm never going to put up with it again'.
Superordinate Theme Six: *Navigating New Relationships*	
The sense of the participants / couples 'moving apart' grew stronger here.	I have made no mention of actual time frames as the 'movement' and processes felt very psychological rather than concrete and tangible. My only caveat on this point is that the particular theme that best fits particular women / couples almost certainly relates to time in-remission as well as others factors (see below).
Positive expectations	Here I present extracts which show a very 'positive' current location. However, I do again make the point that optimism and positivity may mask *'worry'* and could lead to deep disappointment if their partner takes up drink again (particularly for Christine and Olivia).
'One day at a time' *I don't expect him to drink tonight because he knows he will be letting me down* [Gemma]	The extracts in this subtheme exude caution and we'll wait and see, or like the extract opposite, which presents quite a modest hope / reasonable goal – hence the 'one day at a time'. The extracts here also seem to have a very cognitively active / vigilant quality, whereas above seemed much more idealized and, like the 'Halcyon Days' rather 'rose tinted'.

'Living together alone'	This subtheme was predominately derived from two women for striking different narratives / reasons. Namely Sandra who appeared, sad, lonely and potentially depressed, and, Ruby, who is essentially getting on which her own life although she owns that she will never leave Ray (she did start to seek a divorce but this was for his infidelity, not his drinking) because she still loves him.
Sandra's potential depression.	As a counselling psychologist it was very difficult and painful at times to listen to Sandra's story of loneliness and isolation, possibly mild depression. I was conscious of thinking she desires and needs more happiness that she is experiencing, but it was not mine to give.
"Resignation" .v. "Acceptance" *I've come to understand it's not him it's the alcohol which takes him away from me.* [Ruby]	Ruby also seems to have developed a quiet acceptance (rather than resignation?) of Ray's inability to be her soul-mate when he's drunk. This was one of the distinctions in the research that I found quite difficult to make. I see acceptance as much more 'positive' in that there is a sense of having thought about and come to an 'inner peace' or 'happy' resolution. Resignation 'feels' much more begrudging and almost as if the issues are still very much near the 'surface'. Acceptance felt right for Ruby and it resonates with the teachings of Al-Anon and The Serenity Prayer'.
General Issues	
Some extracts / themes required 'extra' consideration of whose perspective was at issue (partner, 'drinker', general). Such fine distinctions apparent re early themes e.g. "Insight", "Strength", "Coping Strategies". For example, an early theme, "Insight" was reserved for	

participant's *self*-discovery, whereas insight into the nature of their partner's drink problem (i.e. whether it was believed to be an illness or personal weakness) was often placed in "lay theories".	
Language Use: There were a number of times when I would have liked to be able to spend more time of the fine-grained functionality of talk and explore its minutia. For example, Christine's differential use of first and third person language for example or the women's various uses of alcoholism, illness or various euphemism's for being drunk. I was also interested in Mary's narrative when she described Martin referring to her leaving him for a short while and going to her sisters *as "my little jaunt"*. We spent some time on this as Mary felt this was very unfair and dismissive of her anxiety and distress at the time. She made it clear that it was a sign that Martin was not taking her seriously. I was also very struck by Heather's reference to Henry (when he walked into a crowded room) as an *"atmospheric hoover"*. Knowles and Moon (2006) Introducing Metaphor is fascinating in this respect and helps us to see how we take for granted in language use.	I am conscious that I spent relatively little time and focus on specific language use (although I explicitly predicted that this would be the case given the focus on lived experience and IPA, rather than Discourse Analysis per se). When I was thinking about these sorts of extracts I was reminded of Ussher's (1998) discussions of feminist's scripts and issues of materiality, power, differential status, abuse of power and so on. I am keen to explore such aspects at more depth – if I get the time. Similarly, later stages of analyses pointed towards difference types of communication between couples; again scope for further work. Again I would like to explore these aspects of language more fully. Heather's expression here reminds me very acutely as to IPA's valuing participants as 'experts' in the phenomenon under investigation – without this rich qualitative input you could not predict such vivid and expressive language. I was similarly 'humbled' and taught by 'Alison' (Shineborne and Smith, 2009), a recovering alcoholic, whose sea, wave and storm metaphors were so evocative.
Emotions: There was a wide range of emotions	I was primarily guided by the women's

embedded within the narratives. Some were 'positive': Love, happiness, pride and excitement. The majority were 'negative': Worry, anxiety, fear, disgust, embarrassment and shame (although a relatively small amount – see above). I have tried to convey the emotional aspects of the women's lived experience, but this was a difficult and challenging task. I refer to the limitations re emotions in the portfolio and the difficulty in adequately defining them (e.g. Butt, 1999), and hope to make up this 'shortfall' in the not too distant future. This links to my desire to research metaphors more deeply. Love is a good case in point – there were a number of references to love and I see these as ultimately unique and unknowable by other, although we share some common understandings	narratives and their labels for emotional experience but also tried to 'feel' with them when the situations were complex and ambiguous. It reminded me of my work as a person-centred counsellor where you cannot just assume you know what a client means when they say they were angry or in-love and so on. Often you need to ask in an attempt to gain empathetic understanding (which is not so appropriate in a research context – although I did seek clarification as needed). Consequently, I may have emphasised cognitions and emotions were left somewhat under-explored? I was also conscious of the important functional aspects of discourse and use of emotions within them. For example, the women telling me that they loved him may have been used as a 'conversational full stop' – saying 'I don't really want to explore this anymore as it makes me feel insecure'. This reminds me of Strube's (1988) work which noted the reference to love in abusive relationships. Also see Towns and Adams (2000) for discourses of love in violent relationships.
Interpretation: Following Willig (2012) I have been conscious of the distinction between empathetic and suspicious interpretation and have explored both (as also advised by Ricoeur, 1996) to generate satisfactory insight.	Empathetic interpretation elaborates the meaning within the material itself – I see this as very similar to active listening or person-centered listening to understand an individual's frames of reference. Suspicious interpretation involves bringing out latent meaning / or that which is actually obscured by appearances. These two forms of interpretation were seen as concerned with understanding and explanation respectively (Willig, 2012).
Ethics: A consideration of ethical issues involved in the care of participants (and their partners in this case) meant that I decided against providing details of David's work "trauma". Suffice it to say	I would like to read and think further on such ethical issues including Willig's (2012) work on the ethics of interpretation. I would also like to track down a reference form a doctoral peer which gave an account of a young Phd student, who interviewed many members

they concerned seemingly serious issues of professional misconduct, many of which had not been effectively addressed and/or resolved. I felt under obligation to protect David by not writing about situations that *he* may have chosen to withhold.	of a tight knot fishing community, published her work, then re-visited the community to find that they had been really upset, distress and felt betrayed as she had revealed very intimate details, examples and so on of affairs, liaisons and opinions in a very 'unfiltered', careless fashion. She was very sorry, but would probably never be able to repair the damage.

Exemplars of Analytical Decisions and Development of the IPA

Appendix 10
Interview Schedule

- How you **met** your partner?
- How would you describe / **define** their drinking?
- **When and how** did you start having concerns about your partner's drinking?
- **Current 'place'** / status re drinking.
- **Describe** some of the **EVENTS** / things that happen in your life, that come to mind that relate to your concerns about your partners' drinking – major, minor, everyday, etc.
- I want you to think about your **future** – what **EVENTS** come to mind? Ask re good and/or bad depending on what they say
- **Do you talk** about your partner's drinking? **If so how?**
- How do you feel about talking / thinking about future events? Do you have any sense of **talking about things will cause them to happen?**
- Are you OK?
- Any questions?

NEED:
Info Sheet
Consent Form
Biographical Form "Only info I need not just curiosity".
Recorder x2

Appendix 11

Participant Information Sheet

My name is Angela Bradding and I am following a Professional Doctoral Programme in Counselling Psychology at City University, London.

As part of the course and qualification, I am conducting research into what it is like to live with a partner whose drinking has significantly affected your lives and relationship. Essentially I am looking to explore the issues and concerns that arise may arise whilst living with a drink problem (defined by your and your partner's experience). I appreciate something of how difficult and potentially distressing this can be (and also how this *can* bring couples closer together). I am motivated to develop an approach to understanding how different thoughts and emotions influence people's lives in the face of challenges such as a drink problem. I hope that this work will be of benefit to you, your partner (through you) and to others in the future. I am focusing my research on the ***partners*** of people with a drink problem in this phase of my work, to provide some insight into this perspective, as partners can sometimes feel a little isolated and in need of understanding?

I need to select participants on the basis of the following criteria:

- You are a male / female, heterosexual ***partner*** to someone who has an acknowledged drink problem.
- This acknowledgement was made at least a year ago. Psychological evidence shows that after the first year, people are more ready to reflect on positive changes to their lives.
- You need to be between the ages of 35-60 (as this seems to be a stage of life which allows significant scope for reflecting on a variety of outlooks on life).
- You are living with your current partner who is your sole partner.
- You were born in the UK and have lived here all your life (people's understanding and interpretations of their lives vary according to cultural 'rules').

If you satisfy these criteria and agree to take part, this will involve you having a one-to-one interview with me for approximately one hour.

If you agree to take part and have signed an Informed Consent Form I will arrange a mutually convenient interview time. I will need to record our sessions so that I am able to analyse the content and may use some

details in later publication/s. However, all names and personal detail will be kept confidential and any data used will be anonymous.

I appreciate that some of my questions will prompt you to think of aspects of your life that have been affected by your partner's drink problem and that you might find this distressing. If this is the case and you feel in need of support beyond our therapeutic discussions, please discuss this with me and I will help to make suitable arrangements.

I also need to make it clear that you can decide to withdraw from involvement in this research at any time.

I have included my contact details and those of my supervisor should you need to contact either of us for any reason.

Thank you for taking the time to read this information, I look forward to working with you.

Angela Bradding
MSc. Counselling Psychology.
[redacted]

Don Rawson
Project Supervisor - City University Tel x4830
[redacted]

Appendix 12

Informed Consent Form

Doctoral Research at City University

This research involves me collecting and analysing data collected from a one-hour face-to-face interview with you. Although we will engage in conversations that may hopefully provide you with some insight, support and benefit, these **will not be counselling sessions**. However, I will be mindful of my knowledge of psychology and my professional training in all of our contacts and everyone involved in this research will be operating under the British Psychological Society (BPS) Code of Ethics. As such, all information will be made anonymous and personal biographical details will be treated as confidential. You are free to withdraw your consent at any time and end your involvement in this project – I will destroy any information that I have collected from you in this case.

Gaining **informed consent** in another important part of ethical procedure. I would like you to read the following statements, so that you are aware of the research commitments and your rights as a research participant.

Please sign only after you have read and ticked all the statements below:

I have read the Information Sheet and understand the purpose and nature of this research.

I understand the 'tasks' and time commitment involved in this research.

I have been given the opportunity to ask any questions about this research.

I understand that I can withdraw from this research, without problem, at ***any*** time and that all material generated will be destroyed.

I feel satisfied that this research appears well organised and properly supervised.

I have been given the contact details of the Project Supervisor should I have any concerns.

I understand that you will need to tape and fully transcribe our sessions and may use them in future publication/s, once they are made anonymous to source.

I am now able to give my **informed consent** to participate in this research.

Name of Participant ……..

Signature ……..
Researcher - Angela Bradding
Signature ……..
Date ……

Appendix 13
Biographical Information Sheet

Name …….
Contact No ……..
(Can I leave a message? Y / N)

Age ☐ Age of partner ☐ Sex ☐

Born in UK ☐ Continuously resident in UK ☐

Sole partner? ☐ Living together? ☐ Length of partnership ☐

When problem was noticed / diagnosed……..……..
Still drinking Y / N
Ever had counselling? Y / N
Children? Y / N
If yes brief details

PTO – for any additional information.

Appendix 14

Ethics Release Form for Psychology Research Projects

All students planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor**, together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- Students are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ☐ MPhil ☐ MSc ☐ PhD ☐ DPsych **X**

n/a ☐

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

An exploration to identify pessimistic *and* optimistic obstacles to well-being, in middle-aged individuals who have concerns about their partner's drinking habits.

2. Name of student researcher (please include contact address and telephone number)

Angela Bradding
Colchester
ESSEX

3. Name of research supervisor

4. Is a research proposal appended to this ethics release form? Yes No

5. Does the research involve the use of human subjects/participants? Yes No

If yes,

a. Approximately how many are planned to be involved?

Phase I – Screening survey to identify 15 participants for phase II.

Phase II – In-depth exploration – 15 participants.

b. How will you recruit them?

Phase I – recruit in a variety of ways: snowball / chain sampling / approaching individuals in Colchester town centre; possibly writing a newspaper / magazine article and including my project email address for potential participants [redacted]

Phase II – I aim to identify at least 15 participants from Phase I.

COREC ethics approval will not be required.

c. What are your recruitment criteria?

- Partners of those whose partners drinking habits influence their thinking about the future. These participants may have identified other concerns (such as with diet or smoking from the Phase I screening) but drinking is what most concerns them.
- Neither participant or partner have any major health problems as far as they are aware.
- The non-participant partner has engaged in current drinking habits for a least a year; as the participant may be more able to consider benefiting from sharing their experience (as opposed to being more involved in making sense) of the experience (Davis et al, 1996).
- Middle-aged participants (40 or 45 – 60? – I am in the process of researching and deciding on the age definition of middle-age). Consistent with empirical evidence re significant benefits to exploration of optimism and pessimism at this life-span period (Shultz et al, 1996; Herzberg et al, 2006 and others)
- Heterosexual couples – for practical / homogeneity of sampling purposes.
- Current partner is the first and only – for homogeneity of sampling purposes.
- Born and continuously resident in the UK – again so as not to split the sample as optimism and pessimism (and their meta-cognitions) are influenced by cultural variation (Chang and Sanna, 2001; Wells, 2000 and others)

(*Please append your recruitment material/advertisement/flyer)* –

Recruitment Flyer will vary according to location / source of sampling but all recruitment material will:

Carry sufficient details for the participants to give informed consent.

Carry Don's details (name, professional status, City contact details)

Details as to the benefits for the participants.

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent?
Yes No
e. If yes, will signed parental/carer consent be obtained?

N/A

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Requirements / commitments are as follows:

Phase I – A brief screening survey in order to identify potential participants. I will ask for brief biographical details (age; length of partnership; born and continuously resident in the UK – tick a box). I will list various health risks such as smoking, drinking, weight/dietary concerns and again tick boxes. If the respondent does not 'tick the right boxes' I will thank them for their information and ask them whether I can use their responses (in a totally anonymous way) to present a tally of responses. I will destroy their responses if they do not give their permission.

If the respondent does satisfy my criteria I will ask them whether they would be willing to consider sharing their experiences of living with a partner whose drinking habits influence their thinking about the future in two 1-hour interviews (Phase II). If they agree I will give them a copy my information sheet, obtain their informed consent and arrange the first interview.

TOTAL TIME commitment – approx 5-10 minutes.

Phase II – 15 participants (in order to generate sufficient data for a content analysis on the basis of at least 300 content statements needed, at an average of 22 per participant).

Interview A / Initial Assessment (approx 1)

i) Administer LOT- R optimism-pessimism – approx 5 minutes.
ii) Semi-structured interview based around the structure of Attributional Style Questionnaire (questions related to optimism and pessimism in relation to partners drinking habits, degree of closeness of partnership, level of well-being and so on – approx 40 minutes.

Interview B / clarification and feedback (approx 1 hour)

I will present participants with my analyses of their optimism and pessimism (amalgamating all info from Interview A). I will then explore and negotiate (using PCT, CBT/REBT approaches to the discussion as appropriate) a list of potential obstacles (for acceptance and/or change) in order to provide the participant with a number of areas for their own reflection and/or action as determined by them.

I will thank participants for their involvement in the research, de-brief them and explain that I will be sending written summaries and further support details.

TOTAL TIME commitment is approx 2 hours.

I will tape both interviews.

Whilst this project does not involve counselling per se I will be conducting all aspects within a therapeutic milieu. I will use my counselling skills and experience and work within counselling codes of conduct for establishing, maintaining and ending a

therapeutic alliance. This is particularly important for the individual interactions contained within Phase II, although in Phase I will require mindfulness of counselling practice and good closure.

Psychometric Measures

LOT-R is included in Appendices along with scoring procedure and copyright / reference information. This is a very widely used, quick and simple measure, so I am assuming that the level of qualification required for use is fairly modest?
The Atriibutional Style Questionnaire" (ASQ) and C.A.V.E. will be scored using instructions contained within the article on the original ASQ and detailed manual for scoring this and other thematic tools (see proposal for details). I am in a position to fully reference these tools.

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7. Is there any risk of physical or psychological harm to the subjects/participants?
Yes possibly? No

If yes,

a. Please detail the possible harm?

There is a possibility that my questions, analyses and discussions could distress the participants by reminding them of their fears and concerns about their partner's drinking habits, the potential risks they may be taking and possible negative impact on their lives as a couple. It may also trigger other negative images, thoughts and feelings.

b. How can this be justified?

The main purpose of this research is to facilitate insight, understanding and openness in all participants (and foster an increased willingness to discuss issues with their partners for participants in Phase II). Therefore, I aim to provide benefit to my participant's, which may involve their willingness to face some difficult issues on the way towards greater well-being.

In order to achieve this aim I propose to use my counselling skills and/or knowledge throughout all contacts. I will draw upon my theoretical knowledge, expertise and experience of both PCT approach (over 100 client hours – bereavement, grief including anticipatory and loss) and CBT/REBT (over 200 hours, predominately with trauma, loss and stress) as appropriate to foster acceptance and/or contemplation of change. Specifically, I aim to create a 'safe' and therapeutic environment in which to explore and/or discuss these negative / pessimistic aspects of experience (alongside a balanced, non-judgemental exploration of their optimistic thinking); in fact they form an integral part of the whole process. Further, I believe (derived from my reading on loss and discussions with my Hospice Supervisor) that I am unlikely to precipitate any thoughts or negative predictions that have not already occurred to the participants prior to my work with them. I believe that I will be in a position to facilitate some positive reappraisal / balance, which allows the participants to enjoy their current health problem free lives.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes No

(*Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)* – Information Sheet is provided in Appendices – will be amended to reflect the reductions.
9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?
Yes No
10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?
Yes No
(*Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)* – Informed Consent Form is provided in Appendices.
11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?
I will be keeping all measures, notes/tapes of discussions.
2. What provision will there be for the safe-keeping of these records?
Written data will be securely stored, in locked premises in anonymous, unlabelled folders. I have security passwords on my personal / sole access computer.
13. What will happen to the records at the end of the project?
All original records will be destroyed at the end of the project. All audio recordings will be deleted. Any 'translations' that are kept will be unidentifiable to source.
14. How will you protect the anonymity of the subjects/participants?
Each participant will be given a pseudonym, which will appear on all materials from that person (I will then destroy original sources of this information). I will disguise, change or delete personal detail (such as names, biographical detail, identifying information) where appropriate, particularly if I am providing direct quotes.
15. What provision for post research de-brief or psychological support will be available should subjects/participants require?
For Phase II participants I will prepare a written summary of our work together and provide this with my Ending Letter (see Appendices). This will include the offer of further contact / opportunity to ask questions (face-to-face if required) / for further de-briefing. I have also included a list of further support options.
(*Please append any de-brief information sheets or resource lists detailing possible support options)* – Have included what I have called my Ending Letter in Appendices.
If you have circled an item in bold print, please provide further explanation here:
1. I have underlined NO to providing my proposal with this ethics form as the only change (from my earlier approved version) is the nature of the participants partner's 'problem' (i.e. potentially riskful drinking habits as opposed to cancer in remission). I am in the process of carrying out a literature search on this new participant population and will inform Don of my progress a.s.a.p.).
I have also underlined YES to using human participants but have made provision for their safe and ethical 'treatment', in line with ethical and professional codes of conduct. Specifically:

I aim to not only adhere to the highest standards of safe, professional and ethical conduct, but to provide all participants with some benefit from taking part in this research. All participants will be given a written summary of their responses and guidance as to how to interpret and benefit from this insight.
All phases will be conducted within a therapeutic milieu and I aim to treat the participant as a counselling client from the outset (although this research does not involve counselling as such) and follow guidance for initiating, maintaining and ending with clients. Thereby minimising the impact of the research aspects for my participants.
I have written a reflective piece (see proposal), which outlines some of the experience and expertise in working with stress, illness and loss, which is relevant to this area of research. I believe that I have acquired insight and ability to communicate about potentially difficult issues, which I can bring to this project.
I will make it clear and explicit that participants are able to withdraw their consent and leave the project at any point and to do so will not affect their eligibility for support / further contact / counselling should they need it (Phase II only). I aim to minimise self-criticism for not completing the programme by reassuring them that they have not let me down by leaving 'early'. I will also provide some written feedback if possible.
Participants will be thanked for their involvement regardless of exit point and regardless of whether 'early leavers' agree to allow me to use the data collected up to that point or not (I will ask directly). I will assume that participants who stay for the entire programme are also still happy for me to include their data into my research analysis. I will state this assumption explicitly on the Information Sheet.
2. I have also underlined YES to *possible* psychological harm, but believe that I have given adequate and appropriate justification.
Signature of student researcher *Angela Bradding* Date 17/01/08

Appendix 15
Addiction Research and Theory: Instructions to Authors

According to the guidelines provided for journals published by Informa Healthcare (as above), manuscripts should be compiled in the following order:

Title Page – To include the names and affiliations of all authors.

Abstract – No more than 250 words. Can be structured or unstructured (as mine is set out). To include at least 6 key words that are not in the title.

Main Text – inclusions as follows: Introduction – including background and purpose; Methods – methods used and procedures, also need to state the ethics approval route/s and bodies; Results – concise and accurate; Discussion – to include the implications and limitations by making reference to other studies and the possibilities that these suggest for future research; Conclusions – ensure that they are justified by the data presented.

Declaration of Interests – all as appropriate.
References – Use American Psychological Association (APA) guidelines.
Appendices – should be avoided if possible, if needed this supplementary material needs to be labelled.
Tables – Arabic numbers to be used, not Roman numerals.
Figures and Illustrations – Aim for the highest quality representations for submission so that high quality reproduction is possible.

Additional notes on style

- Clear, concise English
- Upper case characters for headings and references should be used sparingly
- All acronyms for national agencies and so on should be spelled out first time
- Spell out numbers under and including 10