How do recovering alcoholics, attending Alcoholics Anonymous (AA), view the phenomenon of relapse?

A person-centred study into the perceptions of relapse as they affect the process of securing sustained-recovery from alcoholism

by

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Student Declaration

I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution.

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Dedication

In

Memoriam

PW

"Bonum certamen certavi, cursum consummavi, fidem servavi."

(2 Tim: 4:7)

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Abstract

Within addiction-treatment, relapse from alcoholism is regarded as the most pressing problem facing recovering-alcoholics (Vaillant, 1988) as, in extreme cases, it proves fatal. However, professional research (comprising bio-medical and psychosocial approaches) fails to agree what constitutes a relapse and how best to secure its attenuation (Maisto et al., 2016). The dominant relapse-prevention model (Marlatt and Gordon, 1985) is not proving, universally, effective. Currently, psychosocial research construes alcoholism as a chronic, relapsing illness (Galanter, 2014).

Yet some alcoholics, attending Alcoholics Anonymous (AA), appear to integrate their relapse-experiences positively, securing years of sustained-recovery. Understanding their recovery-process may assist professional clinical practice where, historically, 90% of treated individuals relapse within the first year, *post-partum*.

A purposive sample of six alcoholics, (four men/two women) affiliated with AA and experiencing abstinence-based, longer-term recovery (1-5 years), was recruited within the North West of England. Using semi-structured interviewing, my study applied a Rogerian, Person-Centred Approach methodology (PCA) (Rogers, 1951; 1957; 1961; etc.), to assist participants in describing, accurately, their phenomenological experiences of relapse within their lifespan.

The objective was to re-present an empathic, descriptive and co-constructed expression of relapse within the context of their recovery-process, using their own words, but with a minimum of researcher intuited or inductive interpretation. The use of participant-validation was employed.

Findings suggest that experiencing both relapse and alcoholism is highly subjective but that meaning-making, mercurially, does not have to be logically tenable. Though sustainable, recovery is never considered a stable phenomenon. The self-construct of being *alcoholic*, endorsed by AA's broad, phenomenological overview of *alcoholism*, requires the sacrifice of notions of self-efficacy (abstinence) as regards future alcohol

consumption. However, this is replaced by an autonomous view of self, where alcohol-use is no longer salient. This empowers an individual both in developing coping-strategies and accepting a self-construct orientated towards living in active-recovery.

1.0 Chapter One:

Introduction: Study rationale: Aims and objectives: Organisation of the thesis

1.1 Introduction

My study engages, collaboratively, with recovering alcoholics affiliated with Alcoholics Anonymous (AA). The words *alcoholic* and *alcoholism* may be either diagnostic terms (APA, 2013) or pejorative labels (Kairouz and Dubé, 2000) but are used within this study being derived from the frames-of-reference of its research participants. As volitional members of AA, they use the label *alcoholic* to designate someone who perceives him/herself to be an affiliate member of AA; whereas the term *alcoholism* is used to refer to the subjective, phenomenological experiences of being *alcoholic*. Both terms appear ubiquitously within AA's published literature.

By deploying a Person-Centred Approach (PCA) methodology (Embleton Tudor et al., 2004) based on the writings of Carl Rogers (1951, 1961, 1980, etc.), I seek to describe, in the participants' own words and with a minimum of interpretation, their subjective, phenomenological experiencing and perceptions of relapse. In particular, I hope to gain an insight into the process(es) by which they incorporate their relapse experiences/perceptions into their quotidian lifestyle of abstinence-based, sustained-recovery. Such interpretations that are made derive from the participants' own internal frame-of-reference.

Relapse is expressed by the *addiction treatment and research field* (ATRF), a generic term I employ throughout my study to encompass both bio-medical and psychosocial approaches to the empirical research and treatment of addictions, as an epiphenomenon of alcoholism, having the potential to frustrate successful treatment outcomes (Castonguay and Beutler, 2006). It may be viewed, *inter alia,* as:

- a recrudescence of a condition, susceptible to any number of confounding variables, which have not been, effectively, addressed by the clinician (and client) through the employment of a particular treatment modality (Castonguay and Beutler, 2006)

- or an independent, self-defeating decision by an individual to master his/her drinking, which has been rendered untenable by the phenomenon of alcoholism itself (Donovan et al., 2012)
- or a move towards developing an, as yet, elusive quality-of-life which may still permit alcohol consumption (Tiffany et al., 2012).

Frustratingly, the ATRF fails to establish any consensual agreement as to what it means by the terms *relapse* or *alcoholism* (Babor and Hall, 2007). Instead, it hypothesises that being *alcoholic* is to endure an interminable cycle of remission and relapse (Galanter, 2014). In ATRF terms, relapse involves a data-set of predictive causes and potential outcomes which are subject to treatment, mediated by the clinician and the client's personal goals and motivation (Prochaska and DiClemente, 1984).

This chapter contextualises my thesis within the landscape of current ATRF research. Herein, I examine:

- the clinical problems of relapse
- the division between the ATRF's bio-medical and psychosocial approaches to relapse
- consider the ATRF's failure to define the phenomenon
- describe how its principal treatment models view relapse
- incorporate the view of relapse held by AA (from which the study participants were drawn)
- and outline what I perceive to be the treatment paradox, whereby the diagnosis of alcoholism and the ATRF's treatment of relapse follow divergent epistemologies.

I then compare these with my own clinical background and approach and describe how this provides a rationale for my study and affects its aims and objectives. The chapter concludes with a description of the organisation of the thesis as a whole.

1.2 The clinical problem of relapse

Based on its own testimony (e.g. Barr and O'Connor, 1985; Babor and del Boca, 2003), clinical relapse-prevention treatments appear to succeed in doing little more than

devise and apply cognitive and behavioural coping-strategies which, at best, attenuate relapse but may fail to make any substantive or lasting change and may not always match to the needs of the client (DuPont et al., 2015). Primarily, each relapse-event becomes a *de facto* reactive learning-exercise, prior to the next and inevitable ingestion of alcohol (Marlatt and Gordon, 1985). Such treatment may be effective for some people, but not others, as the cycle may abruptly stop as alcoholism is sometimes fatal and, for any clinician, patient fatality is a difficult psychological burden to carry (Brewer, 2006).

Instead, I suggest that whilst relapse is, for some, an experience which attends the phenomenon of being alcoholic and may happen with some frequency, living in recovery *as an alcoholic* does not, necessarily, require a mandatory state of perennial relapsing. This view accords with the testimony of AA (AA, 1976) and imbues recovery with personal, existential qualities of hope, personal satisfaction and self-esteem (Kelly and Greene, 2014).

Phenomenological evidence for this is furnished by the narratives of my study's participants who, as recovering-alcoholics, are affiliates of AA. By attending to their narratives, it is possible to discern, from their frames-of-reference, their idiosyncratic sense-making of their experiences, as it aids their process of recovery, with the important *caveat* that their personal understanding is unique, intrinsically subjective and may not be generalisable to other contexts.

Within the ATRF, alcohol relapse is sometimes characterised as a return to drinking after a period of abstinence (Edwards and Gross, 1976). Additionally, relapse may occur frequently, with the same individual (Allsop et al., 2000), which has resulted in the current psychosocial conceptualisation of *alcoholism* as being a chronic, relapsing illness (Galanter, 2014) yet without describing it in purely bio-medical terms. How alcoholism is construed affects public policy and societal attitudes towards it (Babor et al., 2010) and, clinically, it creates both positive and negative implications for alcoholics and those seeking to treat them (Keller and Doria, 1991).

Outside this research study, as a clinician attending open-meetings of AA, I can attest to the life-stories of other recovering-alcoholics who, whilst expressing personal and historic relapse-experience(s), nonetheless enjoy decades of sustained-recovery

without any recrudescence of the condition. This not only challenges the *zeitgeist* of ATRF thought, suggesting that alcoholism need not be a relapsing condition, but also delivers the successful outcome which professional treatment is, consistently, struggling to achieve (Truan, 1993).

1.3 The division of research within the ATRF

Historically, addiction research has been a fissiparous division between bio-medical and psychosocial approaches. The former, via studies of humans/animals within laboratory-settings (Littleton, 2000), examines, *inter alia*:

- the effects of acquiring addiction (Robinson and Berridge, 2000, 2001)
- the rôle genetics play within that process (Ducci and Goldman, 2008)
- physiological and neuronal changes caused by addiction (Leshner, 2003)
- predicting which neuronal changes contribute towards dependence and loss of self-regulation (Koob and Le Moal, 1997)
- and the mental-cues which stimulate urges to relapse (Drummond, 2000).

The aim is to produce pharmacological agents which attenuate relapse or allow for moderate drinking (Ciccocioppo et al., 2004).

The latter examines:

- confounding variables leading to addiction acquisition (Castonguay and Beutler, 2006)
- matching addicts to specific treatments (Babor and Del Boca, 2003)
- predicting environmental, emotional and psychological circumstances which potentiate recidivism (Gerwe, 2000)
- with the aim of devising effective coping-strategies which will attenuate relapse (Marlatt and Donovan, 2005).

In comparison with my clinical practice (see below), there appears to exist little consilience within the ATRF between these two approaches except that: first, as noted, research-data is gathered principally from studies of addicts situated within in-patient treatment-settings and rarely when living in established recovery (Laudet et al., 2014);

and secondly, that all addictive substances and behaviours are treated as being of a similar nature in terms of acquisition and effect (DiClemente, 2006).

Consequently, research findings are expediently and vicariously applied to all substance-use-disorders (Nehls and Sallman, 2005). In fact, ATRF research appears to take place within disciplinary "*silos*" (MacKillop and De Wit, 2013: 751) so that it is unclear whether one style of research is aimed at augmenting the work of the other (Kampman, 2009) or is conducted in response to the apparent failure of both to reduce relapse-rates (Yates, 2012).

I acknowledge that this divergent approach may be acceptable for reasons of research time, cost and accessing study groups (Roehrich and Goldman, 1993) and because each discipline examines different aspects of the total phenomenon. I concur that there are observable similarities attending the process of acquiring substance-dependence (Hänninen and Koski-Jännes, 1999) and that relapse-rates, across substances, appear to be roughly the same (Raistrick, 1989).

But, I suggest, such generalisablity is not empirically justified for clinical purposes (Morgenstern et al., 1994) as persons (in treatment) are rarely homogenous in their experiencing (Raistrick, op.cit.) and it ignores, *inter alia*: legal status (i.e. drugs versus alcohol); addictive liability (e.g. heroin versus cannabis); and particular pharmacological properties (e.g. stimulant or depressant) between substances (Ferguson and Shiffman, 2009), which variously effect cognitive-functioning (Hammersley, 1994). Yet it is these properties or effects, I have observed, which may determine a person's drug-of-choice. For simplicity's sake, my study focuses exclusively on subjective accounts of alcoholism/relapse, without the effects of poly-drug-use or other confounding variables.

The lack of agreement as to the causality and treatment of alcoholism is further compounded by the ATRF's failure to provide a collegial definition of relapse itself, which I now address.

1.4 The ATRF's failure to define relapse

ATRF research is replete with ambiguity (Bell and Khantzian, 1991) and lines of enquiry are frequently hampered by the absence of any consensual agreement in defining its key terms (White, 2007a). Since the first characterisation of alcoholism as a *disease* (Jellinek, 1960), the ATRF has repeatedly altered its conceptualisation of alcoholism (Weisz, 2014) as it struggles to:

- predict its causes (Giordano et al., 2014)
- how it is best diagnosed within a general population (Polcin, 1997)
- what constitutes the most efficacious treatment (Castonguay and Beutler, 2006)
- how to match specific treatments to alcoholics (Babor and Del Boca, 2003)
- and how to predict those circumstances under which a person might relapse (Marlatt and Gordon, 1985).

I examine these changes in ontology in the next section.

Only 10% of persons with alcohol problems seek formal treatment (Boschloo et al., 2012) and, of those, 90% will relapse within the first year, *post-partum* (Barr and O'Connor, 1985). This figure may fall even lower (Emrick and Hansen, 1983), depending on how treatment-outcomes are judged, which may affect the expectations of researchers, clinicians and those they treat (Connors et al., 1996). In conclusion, the ATRF currently conceptualises alcoholism (bio-medically) as a *disease of the brain* (e.g. McLellan et al., 2000; Leshner, 2003) for which there is no apparent cure (Gartner et al, 2012) and (psychosocially) as a *chronic relapsing illness* (e.g. Kelly and Yeterian, 2011; etc.). I posit that both these concepts contain different ontological perspectives but refer to the same phenomenon, yet the ATRF fails to suggest that they can or should be utilised co-operatively and so they appear to stand as hegemonic conclusions with little relevance to each other and with little benefit to those seeking treatment (Vrecko, 2010).

This psychosocial conceptualisation is remarkable given that there is no collegial or standard definition of relapse within the ATRF (Hendershot et al., 2011) which

undermines clinical practice in determining successful treatment-outcomes (White, 2007a). For example, the Diagnostic and Statistical Manual (DSM 5) (APA, 2013), cited within many research papers, (see Chapters 3 and 4) is used to locate people on a continuum of addiction-severity extending from: harmful use; to hazardous drinking; and, finally, dependence. This it describes as persistent drinking despite negative consequences and impaired-control over consumption (Babor et al., 2001). But DSM 5 mentions the word *relapse* only twice and fails to define it at all, except to say that: first, it is characteristic of persons who have been diagnosed with substance-use disorders and who can, therefore, be assumed to be dependent on alcohol-use (with all that this bio-medically entails); and, secondly, that the clinical course of addiction is characterised by "*periods of remission and relapse*" (APA, 2013: 493).

Another graphic illustration is provided by a recent systematic review of empirical studies of relapse, (Maisto et al., 2016), which found no fewer than twenty-five different permutations currently employed within the ATRF to characterise relapse and seven to characterise a lapse (or slip), which is distinguished from a relapse as being a single, or discrete drinking episode (Witkiewitz and Marlatt, 2004).

Within the studies it reviewed, relapse was, generally, considered as occurring after a period of improvement, often referred to as "*early remission*" (Maisto et al., op cit), which was ill-defined; or a period of non-drinking, i.e. abstinence (Edwards and Gross, 1976); or as part of a process of change within an individual's circumstances. A slip could be viewed as constituting one drink or multiple days of heavy-drinking. Heavy-drinking was operationalised differently within studies, the most widely used benchmark being 4/5 drinks for men/women on a single occasion, but even the empirical evidence for the utility of this definition is dubious (Patrick, 2016) due, in part, to the lack of standardisation of measuring a unit of alcohol (Osiowy et al., 2015).

1.5 Treatment models and their view of relapse

If, on the one hand, there has been a failure by the ATRF to define relapse, on the other its construal of addiction/relapse has been further complicated by historical changes in its professional philosophies of addiction-treatment. In the order in which they have appeared, the four mainstream approaches have been:

1) **The Moral Model**: this is generally unhelpful for treatment, as it perceives relapse as an exemplar of lack of moral character (Todd, 1882). However, Sholette (1986) argues that this model is seriously under-estimated, not to the exclusion of other models of addiction, but to the benefit of any individual who must deal honestly with the self, in relation to alcohol and assume personal responsibility for his/her abstinence-based recovery. Moral probity and a state of abstinence form constituent parts of AA's philosophy as essential mechanisms for personal growth (AA, 1976).
2) **The Disease or Illness-Medical Model**: was formulated by Jellinek (1960) who codified alcoholism as a medical condition, based on the testimony of AA affiliated recovering-alcoholics. Not all people who drank excessively were to be labelled alcoholic, he suggested, but those who had lost control over consumption and were, therefore, deemed to have the *disease* of alcoholism, could not expect recovery without receiving medical interventions (Fingarette, 1991). This model follows an unequivocal position regarding relapse as being the opposite of abstinence but, medically, assumes that alcoholism is also a chronically-relapsing condition so that relapse is, by and large, an inevitable loss-of-control inherent to being alcoholic.
3) **The Alcohol Dependence Model**: (Edwards and Gross, 1976), although only intended to serve as a discussion document (Babor, 1986), this model views alcoholism as a "syndrome" involving a cluster of unspecified, concurring and integrated phenomena (though it fails to define what it means by this term). Relapse is a symptom of the syndrome or a *return-to-drinking-after-a-period-of-abstinence* and is an autonomous choice *not* to exercise self-control.
4) **The Social-Learning Model**: (Marlatt and Gordon, 1985) views relapse predominantly as a failure to learn adequate coping-skills to deal with risky situations and, secondly, as a lack of self-efficacy in the face of the perceived expectancy that alcohol can mediate a person's mood.

In all these models, loss-of-control is deemed to be both a hallmark of relapse and the acquisition of alcoholism (Bergmark and Oscarsson, 1987) which may also be seen as a failure to exercise willpower. This, according to Damasio (1994/2006), is simply another way of describing an alcoholic's tendency to impulsiveness. But, as Noël et al., (2010) argue, loss-of-inhibitory-control may be more than mere impulsivity as, bio-

medically, it evidences the neuronal disruption of an alcoholic's ability to make advantageous decisions whilst taking into account short-term or delayed consequences. As each theoretical model conceptualises alcoholism in a different way, so their constructs of relapse differ.

My study, however, seeks to understand how lay alcoholics, affiliated with AA, perceive and experience relapse, since it is acknowledged that their understanding may differ from that of professional clinicians (Walters and Gilbert, 2000). Account needs to be taken, therefore, of the lay, phenomenological descriptions of alcoholism provided by AA (1976), which is the largest and, perhaps, the most widely representative body of opinion on the subject provided by alcoholics themselves (Ogborne, 1993); these can be summarised as follows.

1.6 AA's view of relapse

Although the ATRF regards AA with some ambivalence (Ferri et al., 2006), it serves as the primary mutual-help group designed for and by alcoholics (Galanter, 2014) supporting those not seeking clinical assistance, remembering that almost 90% of people facing serious alcohol problems never access professional help (Laudet and Hill, 2015). There is also growing empirical evidence suggesting that AA may enhance/augment professional treatment, *post-partum*, in securing long-term recovery (Kelly et al., 2006).

AA demands abstinence as a prerequisite for its affiliates, which it describes, phenomenologically, as an on-going process whereby any alcoholic, progressively, frees him/herself from the condition of alcoholism. This may involve immediate cessation or an initial attempt at controlled- or social-drinking (Reinert and Bowen, 1968) or harm-reduction, before moving towards complete cessation (Yeh et al., 2009). Some argue that the requirement for abstinence is, initially, too difficult for an alcoholic and, therefore, iatrogenic (Stockwell, 1986). Alternatively, Gomes and Hart (2009) suggest that it aids the well-being of those following an AA programme of recovery and Bergmark and Oscarsson, (1987) posit that it provides a significant motivational goal to avoiding relapse.

AA views relapse as the ingestion of a single alcoholic beverage, once a volitional decision (based on past experience) has been taken to remain abstinent (AA, 1976). As such, AA regularly conflates abstinence to mean the process of recovery itself (Laudet, 2008). My research does not aim to define relapse but this simple, uncluttered characterisation of relapse, used within my clinical practice and by this study's participants, as AA affiliates, is adopted by my study.

Such differing approaches/models affect professional diagnosis and treatments of alcoholism but, in the area of relapse-treatment/prevention, there exists a further paradox. Is alcoholism to be viewed as some form of illness over which the sufferer possesses a restricted means of control or is it a condition (tacitly recognised as being medical in nature) but whose progress can be significantly inhibited/modified by his/her intentionality and agency? I address this question as follows.

1.7 The Treatment Paradox

The principal *diagnostic* criteria for all addictions (DSM 5 and ICD 10) view alcoholism as a medical condition but are influenced in their description of the phenomenon by the Alcohol Dependence Model of Edwards and Gross (1976) (see above) who regarded alcohol-related problems as being bi-axial, i.e. exhibiting harmful (or abusive) and dependent-use, linked to quantity, frequency and patterns of drinking (Li et al., 2007) and where relapse was to be viewed as both deliberate and intentional; i.e. relapse was a choice.

However, the *treatment* of relapse is dominated by the Relapse Prevention Model (RPM) of Marlatt and Gordon (1985). This model, based on the social-learning theories of Bandura (1977), reviews the antecedents of a relapse (assuming that they are causal) in order to identify what precipitated the return to drinking and so help devise cognitive and behavioural coping-strategies which will, hopefully, attenuate future recidivism.

Relapse, in this sense, is not viewed as intentional but serves as a learning-experience due to a *failure to cope* which makes intuitive sense as, by the time a person seeks treatment, the focus is less on what has brought him/her to this decision and more on

how s/he can be assisted to reassert control over his/her life and what strategies s/he can employ so that s/he can prevent what has happened re-occurring. As Rounsaville (1986: 172) has stated:

"... relapse and relapse prevention define the major clinical problems to be faced by clinicians and clinical researchers who do work with substance-abusers."

A view subsequently echoed by Vaillant (1988: 1151):

"...relapse – not dependence – must be seen as the addict's most dangerous enemy"

The significance of the RPM is that, originally, it claimed to provide therapists, of whatever treatment-modality, with an empirical means of addressing all addiction-types; here, at last, was the long-sought universal panacea (Larimer et al., 1999).

However, the RPM is not always:

- sensitive to gender differences in relapse (Rubin et al., 1996)
- does not take full account of internal psychological states which may motivate the desire to drink (Gordon et al., 2006)
- disregards pathological alterations to brain chemistry which could affect decision-making (Silvers, 1993)
- appears to have little predictive value, as situational precipitants may change from one relapse episode to another (Lowman et al., 1996)
- and any success, judging from the ATRF's abysmal relapse-rates (Yates, 2012), appears to be short-lived (Longabaugh, et al., 1996).

In fine, the RPM may be regarded as the seminal psychosocial treatment model for relapse-prevention (Fernandez-Montalvo et al., 2007) but, therapeutically, it is restricted to a cognitive-behavioural approach and not an holistic one. Paradoxically, therefore, alcoholism has become viewed within the ATRF as both a bio-medical problem but where the success of its psychosocial treatment outcomes rest, significantly, with the agency and intentionality of the sufferer.

As a clinician seeking the right tools for the task, my literature search (see Chapter 3) provided little help as ATRF research appears to have reached something of a stalemate as it, stoically, continues to attempt to verify the effectiveness of its current treatment-methods via a repeated analysis of data generated, almost exclusively, from in-patient treatment-settings (Truan, 1993) and through methodological approaches which remain relatively unchanged and for the most part unchallenged (Vaillant, 1983). This is not helped by its failure to define its key terms (e.g. alcoholism, relapse), so that comparing like-for-like studies is almost impossible, (White, 2007a). Instead, as presented by the ATRF, an hegemonic and, at times, *ad hominem* argument has emerged as to whether a bio-medical or psychosocial approach is more beneficial to the treatment of all addictions or which treatment-modality can consider itself *primus inter pares* (Timulak, 2005). There is a:

"... conflict between professions (in this case medicine and psychology) for dominance in a particular field of knowledge." (Gorman, 1989: 845)

At the level of clinical intervention this hegemonic debate becomes confusing so that, for the purposes of this study, my critical response to the ATRF's views of alcoholism/relapse is, perhaps, best illustrated and made clear by describing my clinical practice.

1.8 Reflexive Position re my clinical practice

Working in the field of addiction meant that I found myself struggling with the cumulative effect of witnessing clients die through relapse; each death increased my sense of despair, not just with me as a clinician, but with the apparent ineffectiveness of the models of treatment available. The final drop in the bucket which caused the whole to overflow was the death of a young mother of two, whose compliance and level of engagement with therapy had more than matched all the empirical findings of contemporary research. This resulted in my feeling as if I was staring into a baffling cloud of unknowing; why did there seem to be a mismatch between claims of professional research and the successful recovery narratives of AA members which I heard in their open meetings? When exploring this conundrum within clinical

supervision the thought gradually emerged that perhaps relapse was being viewed from the wrong angle. Instead of theorising how the threat of relapse could be staved-off (given that current research appeared to provide no predictive value as to who would and would not relapse), would it not be advantageous to ask those who lived relapse-free lives how this was achieved? In other words; how did recovering-alcoholics attending AA avoid relapse?

There are many pathways to recovery and I am not, as with AA, advocating abstinence as the *conditio sine qua non*, though for severe drinkers it may be their only option to recovery (Robertson, 1987). From a clinical perspective, a phenomenological appreciation of relapse depends on whether, as his/her personal treatment outcome-goal, a client chooses to embrace abstinence (Donovan et al., 2012) or controlled-drinking (Tiffany et al., 2012). This binary construct may motivate a person to remain abstinent but, if unintended drinking is resumed, may potentially create an *abstinence violation effect* (Marlatt and Gordon, 1985) or a sense of failure, leading to increased negative-affect which, in turn, may serve as a trigger to further relapse (Connors et al., 1996). Though many therapeutic modalities will claim salience in the treatment of addiction, i.e. getting a person sober or improving their quality-of-life (Castonguay and Beutler, 2006), the dominant psychosocial clinical treatment for *relapse* remains the RPM of Marlatt and Gordon (1985). It is this model, in the absence of an empirical alternative, which I currently follow.

Initially, in undertaking this research and having no experience of the phenomena under observation, I assumed the rôle of critical observer which mirrors that of my clinical practice. Similarly, I tried to place myself in the position of a patient being told that the (professional) construal of his/her condition was that of a chronic, relapsing illness (Galanter, 2014). My reaction to this belief was a feeling of abandonment and a complete absence of hope. If alcoholism was perennially relapsing, then it was futile to expect that any form of successful recovery was achievable through professional help; I was doomed. In consequence, if I was alcoholic, my preferred option would be to follow the ideology of AA which powerfully offered the promise and hope of a life free from active alcoholism, "*rarely have we seen a person fail who has thoroughly followed out path*" (AA 1976: 58). This fuelled a further motivation for the study which

was to provide some hope for a successful treatment outcome where, currently, professional teaching suggested there was none.

By comparison, my clinical practice has involved treating alcoholics within a psychiatric hospital but as part of a multi-disciplinary team. I subscribe to this holistic and integrative approach, combining bio-medical (pharmacological) and psychotherapeutic (psychosocial) disciplines, which holds that a mixture of pills *and* therapy is perhaps more effective (and collegial) than monotherapy (Prosser et al., 2016). The length of treatment follows a standard 28 days in-patient stay and a period of one year's aftercare (McKay and Hiller-Sturmhöfel, 2011).

Bio-medical colleagues present and treat alcoholism as:

- a pathological alteration in brain chemistry (Wright, 2011)
- caused through an overwhelming motivation to seek out an addictive-substance (Robinson and Berridge, 2001)
- a loss of ability to regulate intake (Baumeister and Vonasch, 2015)
- and negative mood, often accompanied by a physiological affect when denied access to the substance, i.e. withdrawal (Stahl, 2008).

Though not a medical practitioner, with this I can concur.

However, in conjunction with my psychotherapeutic colleagues, I view and address relapse as:

- a learned-behaviour; determined by a host of personal variables, e.g. gender, age, socio-economic status, genetic predisposition, etc., (Castonguay and Beutler, 2006)
- resulting in obsessive thoughts about drinking and compulsive behaviours designed to satisfy urges to drink, termed, craving (Marlatt and Gordon, 1985).

A purely bio-medical perspective would question the efficacy of applying cognitive-behavioural strategies in real-world relapse situations (Sinha, 2012), though in clinical settings I have noticed that they can be learned, up to a point. The unanswered question, I suggest, is for how long this learning is retained or applied (Prochaska and DiClemente, 1984)? My study seeks to address this conundrum.

I aver that whilst these disciplinary ontologies differ, within a treatment-setting they are complimentary and not hegemonic, being applicable at different stages of the treatment process. For example, the matutinal process of providing relief from the physiological symptoms of alcohol-withdrawal demands a medical/pharmacological intervention (Becker, 2008). Later, in effecting cognitive-behavioural change and learning pro-social coping-skills, a psychotherapeutic approach predominates (Marlatt and Gordon, 1985).

Furthermore, I suggest that a consilience between these two branches of addiction treatment means that potential deficits in one may be reduced by the other. For example, the ATRF designates *loss-of-control* as being the hallmark of alcoholism acquisition and relapse (Bergmark and Oscarsson, 1987). However, this phenomenon is not, as yet, susceptible to any known pharmacological intervention (Volkow and Li, 2005), which has previously strengthened the bio-medical argument for abstinence-based recovery, *post-partum* (Wright, 2011). Conversely, *loss-of-control* is considered amenable to psychotherapeutic interventions, being regarded as teleological or intentional and which can be reclaimed during treatment, thereby rendering controlled-drinking, potentially, feasible for some (Marlatt and Gordon, 1985).

Additionally, a multi-disciplinary approach calls for close attention to a clients' subjective frame-of-reference (how they think and feel about alcoholism) (Hammer et al., 2012) which is often missing from ATRF research (Nixon and Solowoniuk, 2005) and may differ from views held by professionals (Walters and Gilbert, 2000) which could easily be overlooked by clinicians and researchers working in isolation (Cheney et al., 2009).

For example, the ATRF may be doubtful about the veracity of self-report (Maisto and Connors, 1990), but a person's description of reduced fear and anxiety accompanying alcohol consumption (Kelly et al., 2009), may provide an insightful phenomenological narrative illuminating the experiencing of the biomedical process of the brain's stimulation, in those areas responsible for anticipation and pleasure, through the release of the neurotransmitter dopamine (Stahl, 2008).

I claim no medical expertise and my critical reaction to the phenomenon of alcoholism/relapse, as an addiction clinician, is grounded within my psychotherapeutic

practice. It is through face-to-face encounters with recovering-alcoholics that I seek to gain insights into the lived-experience of the phenomenon. Though I make some reference to bio-medical research and acknowledge the discipline's salience, for the purposes of this study I am largely excluding this area of expertise.

1.9 The rationale for my study

Consequently, based on observations within my own practice, I can agree that for *some people,* within the initial stages of recovery, the potential to relapse appears problematical. But I suggest that the ATRF's current theoretical conceptualisation appears too generalist, damningly hopeless and an iatrogenic jeremiad, implying that recovery is simply beyond the abilities of some alcoholics to secure, whilst failing to indicate who those people might be (Polivy and Herman, 2002). Conversely, I can agree that such a prognosis could be a realistic inference drawn from research-data gathered from studies of alcoholics within in-patient treatment-settings and follow-up to one-year, *post-partum*, this being the ATRF's usual research-pattern (Cloud et al., 2004).

Effectively, this maintains what Gossop (2008) terms a *clinical fallacy*, whereby clinicians and researchers, alike, reach hypothetical conclusions which, over time, come to be treated as fact, but are based solely on the treatment of those who are unwell, but with no reference to those in recovery. Herein lies the rationale for my study. In order to gain an understanding of the recovery-process and the rôle which the experience of relapse may or may not play within it and which is not being, currently, addressed, clinicians need to engage with recovering-alcoholics with the necessary lived-experience (Subbaraman and Witbrodt, 2014), otherwise we will be forever engaged in what Reinarman (2005: 311) terms "*conceptual acrobatics*".

1.10 Aims and objectives

I have sought to show how my study has emerged within my clinical practice and from personal reflexivity regarding both the disparity between the bio-medical and psychosocial attitudes towards alcoholism and my current use of the RPM (Marlatt and

Gordon, 1985). Though, empirically-based, I am not convinced that the RPM (as a cognitive-behavioural approach) is consistently effective for all clients. (I had not excluded the possibility that this may have been due to clinical competence).

As a person-centred psychotherapist, working within addiction-treatment, the phenomenological lens through which my study is conducted is the participants' fame-of-reference. Therefore, the objectives of this study are:

- to understand how relapse is perceived by recovering-alcoholics affiliated with AA
- how that subjective experience is incorporated or integrated into the wider phenomenological process of living as an alcoholic-in-recovery.

By stepping outside the usual parameters of ATRF research and by employing a Rogerian person-centred approach, in which I was trained as the modality of my general therapeutic practice, my aim was to gain access into the existential and phenomenological field of a participant in a non-directive way (Worsley, 2002).

Based also on the premise that sound reflexive practice involves learning from the client (Casement, 1985/2008), I eschewed the usual privilege of the professional researcher/clinician as being "expert" (Vrecko, 2010). Instead, I intended to engage, collaboratively, with recovering-alcoholics who were being regarded, by me, as "*experts by experience*" (Slade et al., 2012: 353). Additionally, any findings would be subject to validation by the participants themselves (Sandelowski, 1986). From this validation process could be discerned not only aspects of comparability between participants, but equally areas of difference; their experiences would not be reduced or presented as being "unified" or "typical" of the phenomenon under enquiry (Steffen, 1997).

Instead, a dyadic approach would, potentially, reveal intrinsically subjective and richly descriptive, phenomenological accounts of alcoholism/relapse. These I would re-present, with a minimum of interpretative analysis, beyond that inherent in all human interacting (Worsley, 2002), as narratives of the lived-experiences of a phenomenon as they were co-constructed within a collaborative and dyadic/dialogic encounter between two persons (Gillon, 2007), under certain circumstances and at a single point in time. This approach would endeavour to view the phenomenon of relapse through

the participants' eyes and embedded within their current way-of-living (Rogers, 1951). Consequently, this could help inform opinions about relapse/alcoholism not considered by the ATRF and create a substantially more compelling perspective (Meisel and Karlawish, 2012).

What my study did not propose, was to reduce the participants' narratives to a series of codified and generalist themes by relying solely on my own professional inductive interpretation, nor to create a substantive theory about relapse, either of which were intended to be transferrable to different contexts.

To accomplish my goal, I needed:

- to present the background to the study by undertaking a structured literature search which would broaden my understanding of alcoholism/relapse and contextualise my research within the ATRF. By reviewing the literature, I could identify gaps within the ATRF's knowledge
- make clear my reflexive understanding and assumptions about alcoholism/relapse
- establish a clear criteria for participant inclusion
- refine my research question
- secure a cohort of recovering-alcoholics who had experienced relapse(s), but now lived in sustained-recovery (1-5 years)
- interview and transcribe the participants' lived-experience
- confirm a methodology which, sympathetically, addressed my research question
- test this methodology via a pilot study
- explain my methods of data analysis
- write a descriptive re-presentation of each participant's perceptions of alcoholism/relapse
- and conclude my thesis with an overall summary and appraisal of its limitations.

I will now describe how this relates to the structure of my thesis.

1.11 Organisation of my thesis

This section outlines the structure of my thesis in order to address the several points mentioned above. Each chapter includes:

- a brief introduction
- cites, where applicable, any relevant theory pertaining to it
- offers a full description of the issues presented within the chapter.
- and concludes with a summary.

Chapter Two: although reflexivity is not restricted to this chapter, this reflexive chapter serves to make my own agency and bias within the research process transparent. I present my *a priori* assumptions that the ATRF minimises participants' subjective experience in favour of a researcher-informed, generalist and utilitarian approach, evidenced by its current research methods, particularly as they inform diagnosis and treatment. My critical reaction to this belief informs the deployment of a methodology (the PCA) which addresses the primacy of a person's unique perceptual field.

Chapter Three: outlines my search criteria and differing strategies applied at the various stages or phenomenological journey of my literature search (Greenhalgh and Peacock, 2005). I detail my reasons for undertaking two manual searches of the literature and how this contextualised my study within current ATRF research practice; broadened my understanding of alcoholism/relapse; and explained why no pertinent, extant literature, covering lived-experiences of relapse within recovery, was found.

Chapter Four: offers a critical appraisal of 77 papers employing seven different methodological approaches, used by the ATRF, in studying lived-experiences of addiction/relapse. The chapter suggests that current ATRF research effectively sidelines the unique experiences of alcoholics in favour of researcher-interpreted accounts of experience. Particular reference is made to interpretative phenomenological analysis (IPA) and the limitations of this style of enquiry. A synopsis of each paper is provided with the reasons for its de-selection.

Chapter Five: details a consideration of ethical issues relating to my study: gaining ethical approval; the ethical framework of my clinical practice; and the ethical integrity of the PCA. It reveals how I reflected upon and addressed the subject of academic rigour (i.e. credibility, dependability, confirmability and transferability) as it applied to my study (e.g. Lincoln and Guba, 1985). This chapter examines the importance of participant-validation serving as a key component of my study's ethical stance and academic credibility (Sandelowski, 1993).

Chapter Six: reviews current research methodologies identified by Creswell (2007) and McLeod (2001, 2011); my initial consideration of a *bricolage* approach for the study (Brannen, 1992; West 2013); my thoughts concerning a phenomenological approach and explains why my final choice rested on a Rogerian person-centred approach (PCA). It describes the philosophy underpinning the use of the PCA within a phenomenological research-setting and why I consider it, in the context of this study, apposite to elicit the subjective accounts of lived-experience of alcohol/relapse.

Chapter Seven: provides an account of the pilot study undertaken to discern: whether the PCA methodology was feasible and practical; whether my research question had validity; the research topic was engaging; and what quality of data my study might yield (Leon et al., 2011; West, 2013).

Chapter Eight: describes the extensiveness and appropriateness of my purposive sampling process; the formulation and use of my inclusion and exclusion criteria; and how and why participants were recruited from AA. The unforeseen difficulties affecting participant recruitment are also explained.

Chapter Nine: outlines my study's interview process; its method and stages of data analysis which explored alcoholism/relapse from differing phenomenological and existential perspectives; and how I formed the descriptive re-presentation of the participants' narratives. In gaining access to a participant's phenomenological field, attention is drawn to their idiosyncratic use of AA-derived and eidetic metaphors and the differences between the two.

Chapter Ten: presents my study's findings and re-presents, in their own words, each of the participants' narratives of alcoholism/relapse within their lifespan and the process of their recovery alcoholism.

Chapter Eleven: provides a discussion on my study's findings, noting that though similarities between narrative accounts of alcoholism/relapse may exist, recovering-alcoholics understand or make sense of relapse in an intrinsically subjective manner, so that reifying their experiences into a set of themes, is not germane to representing their process of incorporating a relapse experience into their recovery lifestyle.

Chapter Twelve: summarises my thesis by offering a suggested clinical-model, drawn from the participants' frames-of-reference and illustrated with *in vivo* quotations, which describes how the participants' on-going sense-making of relapse alters their self-construct thereby strengthening their, quotidian, process of securing sustainable recovery.

Chapter Thirteen: offers further considerations from the study and identifies some limitations of my study, particularly as regards: sample-size; the use of self-report; the influence of AA; the use of semi-structured interview questions; participant evaluation; the use of the PCA; and the method of reporting my study's findings. It includes a reflexive insight to my learning experiences derived from the PhD process.

1.12 Chapter Summary

After various historical attempts to conceptualise alcoholism, the ATRF has concluded (bio-medically) that it is incurable and (psychosocially) that it is a chronic, relapsing illness. However, it appears unable to define, collegially, what it means by relapse (Maisto et al., 2016) and its current treatment methods are unsuccessful at attenuating the problem (Yates, 2012).

Setting aside the lack of consilience between these two wings of ATRF empirical research, within this introductory chapter, I have provided the background to this impasse and the rationale for my study. I have suggested that a major stumbling-block to ATRF research is that it focuses on people who are undergoing treatment and who are not, therefore, representative of a wider population of recovering-alcoholics. There are certain elements, within the ATRF, who suggest that experiential and phenomenological studies of alcoholics, in longer-term recovery, are becoming increasingly desirable, as this is an area largely unexplored by the ATRF (Subbaraman

and Witbrodt, 2014). Secondly, some insightful understanding of lived-experiences of relapse is now essential (Caselli and Spada, 2015) as addiction-clinicians are being mandated to orientate their interventions towards a recovery-based paradigm (Kidd, et al., 2015).

My study proposes that to develop any meaningful understanding of the phenomenon of relapse the expertise of alcoholics in sustained-recovery may provide critical insights. This, however, means engaging with members of AA, who are, generally, not welcomed within the addiction-debate (Ferri et al., 2006). Furthermore and, potentially, more radically, I suggest that recovering-alcoholics have an understanding of the relapse-phenomenon which may eclipse that of the researcher who may be expected to regard him/herself as expert in his/her field. Consequently, I proposed to deploy the PCA, as my chosen methodology, which champions the participants' internal frame-of-reference as the arbiter of subjective experience and to subject my study's findings to the validation of the participants themselves.

2.0 Chapter Two:

My *a priori* assumptions derived from reflections within clinical practice

After describing my understanding of the theory of reflexivity, this chapter reveals my underlying assumptions derived, primarily, from my clinical person-centred practice, which inform and influence my current study. I focus on the need to place the participant at the heart of research and illustrate this point by comparing it with the ATRF's potential lack of person-centricity within two aspects of clinical concern: diagnosis and clinical treatment. I also explore the rôle of research to inform practice.

2.1 Introduction

The person-centred approach (PCA) underpins my clinical practice and provides not only the methodological framework for my research, but also the analytical research techniques (e.g. empathy, unconditional positive regard [UPR] and congruence) and principles by which I have conducted my study (Mearns and McLeod, 1984). I have attempted to apply these, congruently, throughout the entire research process.

I believe that rather than depend on a researcher's interpretative expertise to reduce study-data to present consensual themes of self-reported experience, as with the diagnostic and treatment procedures for clients within treatment, research participants are to be valued as collaborators in the research process. The researcher is not, automatically, assigned the rôle of primary expert, thereby creating an artificial power dynamic which favours one over the other. Instead, a collegial approach recognises the client's own self-reflexive agency.

My principal assumptions are that the ATRF has reified and, subsequently, imposed a generic understanding in the diagnosis and treatment of the phenomenon of alcoholism/relapse (Gannon, 1984) with little recourse to an appreciation of what it means, phenomenologically, to people whom it labels "alcoholic" and, therefore, experience alcoholism. In particular, I reference below two key areas of clinical practice, the generalist labelling of the condition and any concomitant intervention and contrast these with the subjective phenomenon of the *comparator* (see below)

which, being derived from the personal experiences of clients themselves, may provide insights into the unique way in which they experience relapse.

By exploring, empathically and accurately, the subjective experiences of the participants, my research aimed to provide an account of their internal frame-of-reference and unique perspective in regards to their perceptions of the phenomenon under review, rather than a generalist, over-arching hypothesis of what the experience and significance of relapse might be. Their experiential world is intrinsically personal, complex and in a state of flux, so that research (like recovery) is a process and not an activity primarily focused on outcome; any conclusions given are, at best tentative, subject to change and non-generalisable. The researcher serves to assist each participant in describing more accurately, his/her experiences to co-construct a narrative description of the phenomenon under investigation.

In short, an appreciation of the condition and its attendant treatment will, I suggest, be more effective if a treatment-seeking individual can concur with any professional appraisal of:

- what needs to be done
- how it will be done
- and why its needs to be done and, in the manner suggested.

This provides the client with a sense of ownership with the whole process.

2.2 Theory pertaining to the process of reflexivity

Reflexivity, though ill-defined within research (Doyle, 2012), highlights what Ryan and Golden (2006) term, my participation in the dynamic, inter-related relationships within a given research project. Researcher reflexivity is not "*endless, narcissistic, personal emoting*" (Finlay, 2002: 226), but one means by which academic rigour is considered and demonstrated within a study (Engward and Davis, 2015) by making transparent my agency within the research process (DeSouza, 2004). Reflexivity functions to make manifest those constructs which implicitly and explicitly influence my research agenda (Guba and Lincoln, 2005). Finlay (2008) describes this as reflecting on reflexive-practice or evidencing thoughtfulness and self-awareness within the research process.

Richardson (1992) suggests it identifies and acknowledges the limitations of the study and Schwandt (2007) believes it signifies that I am part of and not separate from my work, permitting both critical inspection of the whole and a self-inspection of my biases and prejudices.

Engward and Davis (2015) distinguish *reflexivity* from *reflection*, describing the latter as expressing a considered *looking-back* on what has happened. As such, they form separate or discrete processes. Accordingly, reflection *on process*, as Casement (1985/2008) argues, involved my diary-keeping, note-taking and the monthly submission of essays to my supervisory team, which became my systematic method (or process) of knitting together, at any given time, the evolving stream of consciousness within my mind. But Casement (op. cit.) also describes reflection *in process,* which occurred during the interviews in the moment-by-moment interplay between two people as half-formed thoughts emerged, unfurled and were collaboratively explored. Seeking the active participation of the interviewees was, I suggest, to make each of their discourses an example of their reflexivity. For example:

"P3: ... The fact I identified it as a parasite was interesting, I'd never really looked at it like that... as I was talking and a ... as I mentioned that, my brain went off on a tangent..." (P3: 407-410)

Equally, this study involved eliciting their self-conscious reflections on their own experiences via a second validation interview, where they commented both on what they had said and how I had re-presented their narratives. Such reflections materially influenced our collaborative findings. Reflexive and reflective statements, from both parties, appear throughout the written thesis.

Here and now, I am applying the term *reflexivity* in two ways: first, as meaning my *a priori* assumptions/observations created from, what McDermott and Varenne (2010) suggest are, theoretical systems of power and privilege, which affected my preconceived description and re-presentation of relapse/alcoholism but, importantly, shaped my research question. In other words: my clinical observations; my previous academic research; my literature search; and my wider reading and immersion within my discipline.

Secondly, in a Rogerian sense in which reflexivity is an expression of my congruence. By this I mean that my inner-experience and self-awareness (i.e. my understanding of addiction treatment, but my restricted knowledge with respect to relapse/recovery) is transparently communicated, within the totality of this study, (Lietaer, 2001). Even though I focus on the experiential world of each participant, my response to him/her originates within my own experiencing and in reaction to what s/he discloses to me at any given moment. The narratives of the participants were accepted by me and whilst I may have tried to guess, empathically, what each was trying to convey, I was not attempting, from any position of authority, to interpret his/her words into any preconceived theoretical construct I was holding or into an emerging thematic analysis which I was trying to create.

My study is underpinned by the belief that, in the treatment of alcoholism, the most effective method of clinical intervention is to understand the perceptual field or frame-of-reference of an individual client, i.e. what makes them drink? This phenomenological approach is expressed by Rogers (1951: 483-484) when he writes:

"The organism reacts to the field as it is experienced and perceived. This perceptual field is for the individual, "reality"."

But it is also to be recognised that each "*reality*", frame-of-reference or perceptual field is in a constant state of flux:

"Every individual exists in a continually changing world of experience of which s/he is the centre."

A problem exists I believe, based on my reading of extant literature (see Chapter 3) and through my clinical application of empirical relapse-prevention and addiction-treatment that, at every stage of diagnosis and intervention, the basis for the ATRF's approach has been grounded in utilitarian conclusions which ignore the unique and subjective experience of an individual or at least shapes them into consensual conclusions where their individuality is lost. This has resulted in the production of standardised formulaic treatment interventions which, though empirically sound and broadly applicable, are not proving effective with certain alcoholics located at the far end of the severity spectrum (Yates, 2012).

Though treatments may claim to match to the particular needs of the clients, in reality, it is they, for reasons of time, cost and expedience who have to conform to the dictates of treatment modalities (Babor and Del Boca, 2003). This belief has informed my choice of methodology (see Chapter 6) so that, as within my clinical practice, I have sought to apply the PCA, congruently, through the whole process of research data collection and analysis.

I now explain why I believe that, if we are to gain any understanding of relapse, it is necessary to pay attention to an individual's frame-of-reference. I illustrate this belief with two examples drawn from my experiences of clinical-interventions; diagnosis (i.e. applying the label "alcoholic") and treatment-intervention. In each case, these processes are not things which are simply to be *done to* a client and in which s/he should be expected to be complicit. Their effectiveness is strengthened, I suggest, if they are undertaken with the participation and feedback/reflexivity of a client, as being relevant to his/her circumstance.

2.2.1 Example One: The diagnostic label "alcoholic" versus the comparator

Within a treatment setting, the word "alcoholic" is used as a diagnostic label (DSM 5/ICD, 10) provided by the ATRF (APA, 2013) to describe the phenomenon, thereby locating an individual on a continuum of severity (Saha et al., 2006) which necessitates appropriate levels of treatment (Babor and Del Boca, 2003). It is a word, however, fraught with negative overtones of stigma (Kairouz and Dubé, 2000) and which, though deemed clinically helpful, may not, in a client's eyes, accurately describe his/her condition. S/he may recognise his/her problematic use of alcohol but shy away from the imposition of such a negative and, potentially, moral evaluation on his/her behaviour. In my clinical practice, I choose not to apply this label believing that it is only useful if a client can discern, even minimally, its relevance to his/her own perceptual field, thereby initiating a process of volitional change; otherwise its clinical effectiveness is questionable.

I suggest that the label "alcoholic" although, perhaps, legitimised by empirical research, is haphazardly used by the ATRF in relation to what a person *does* when drinking and how alcohol-use manifests itself in his/her life, but it fails to explore what

a person *is* or *feels* when drinking. In other words, it ignores the phenomenological (and existential) aspects of alcoholism, e.g. what it means to a person to drink and whether the label "alcoholic" is suitable in matching, congruently, to his/her experiences. The same may apply to the phenomenon of relapse. We may discover what happens when someone relapses but are unclear what the experience feels like or means to the person experiencing it.

Rather than impose a diagnostic label, I have observed that people with alcohol problems (treated or untreated) describe the phenomenon in a variety of ways (e.g. "*heavy drinking*", "*my reward*", "*I can stop if I want to*", etc.,) and, in doing so, have recourse to a phenomenon which I term the *comparator*. I acknowledge that this phenomenon is, perhaps, a defensive strategy which for some may help perpetuate drinking and resistance to change, by comparing how a person perceives/describes him/herself in relation to his/her alcohol-use. AA refers to this process as the phenomenon of "*denial*" (AA, 1976: 570).

Crucially, however, the *comparator* is drawn from an individual's own frame-of-reference, the personal thoughts, needs and perceptions about how s/he views him/herself, thereby determining the salience or absence of alcohol. The *comparator*, in this sense, provides a window through which a clinician can glimpse his/her perceptual field. It indicates, perhaps, a set of criteria, against which each person measures him/herself favourably, indicating that, in his/her opinion, his/her drinking is manageable and controllable and which dictates the level of intervention s/he believes is or is not required. It is through his/her eyes that relapse may be perceived to be controlled and beneficial, e.g.:

"P2: ... I bet I could have a drink and never want another one again..." (P2: 191-192)

The *comparator* may take the form of either a person or a group of people (within an individual's social environment) whom s/he cites as drinking more than s/he does; the implication here being that a client is being targeted unfairly or singled out for special measures. In clients between the ages of 18-25 the *comparator* is usually "youth-culture", with the belief that such excessive drinking/using is normal if not expected

and, because the person is young, little lasting damage is done and what damage occurs will be easily reversed.

Another *comparator* is that of the proto-typical "alcoholic". This mythological figure is, perhaps, a street-drunk or known-person who has been witnessed at some stage in life or, more often, is a compendium of various stereotypical images of “the drunk”, e.g. “The-man-on-the-park-bench.” If not an individual or amalgam of archetypes, this *comparator* may relate to perceived behaviours which could determine that a person may be, validly, labelled "alcoholic": e.g. drinking first thing in the morning; or, as in the example cited above, wanting another drink after initial ingestion. The implication being that, as a client is not or has not done any of these things, consequently, s/he cannot be "alcoholic" so that s/he is safe to drink. The conviction of an individual being *in control* appears to be a central tenet of treatment resistance or relapse, being a pre-judged conception of what constitutes being "alcoholic", against which clients’ measure themselves, but never to their detriment.

Examples of the *comparator* emerged within this study. For example, P6’s self-label the “*functioning alcoholic*” (P6: 105) brought with it the rejoinder, “*come on leave me alone, er, I’m not doing any harm*” (P6: 149). From his subjective frame-of-reference, at that time, his drinking was acceptable as it did not entail “*any harm*” and he functioned. However, were he not to function and, subsequently, caused harm (however he subjectively understood these constructs) then, potentially, he might be closer to accepting the diagnostic label of being "alcoholic".

Rather than deploying the term "alcoholic", I believe that it is vital to gain an appreciation of an individual’s perception-of-self (in relation to alcohol) in order to appreciate how s/he views any need for treatment, otherwise we run the risk of “Nanny knows best.” The ATRF’s reliance on general diagnostic assessment procedures may ignore what it means, subjectively, to be "alcoholic".

2.2.2 Example two: The Clinical Treatment Process

Traditional treatment involves 28-day in-patient residency and engagement with an empirically-based formula of cognitive and behavioural interventions, derived from

clinical observation and researcher interpretation (Castonguay and Beutler, 2006). Whilst treatment seeks to alter a person's perceptions surrounding alcoholism, unless this is initiated within that time-scale, his/her original self-construct may remain little changed and no diagnostic label/treatment, however sound or factual, will have any import or create conditions of change unless a client continues to perceive its relevance.

Clinical interventions are, however, largely based on researcher-driven hypothesis (see Chapter 3) and where there is an attempt to *give voice* to the participants (Larkin and Griffiths, 2002) attending to the uniqueness of experiencing is, more often than not, sacrificed on the altar of achieving a consensus of identifiable themes which summarise the phenomenon collectively (Chapter 4 reviews this in more detail). A client may appear, therefore, to be complying with treatment even though s/he believes that the content of the treatment intervention is not directly relevant to him or her (Nielsen, 2003).

For example, P4, who underwent professional treatment, describes the weakness of the ATRF's collegial approach when he described his own experiences of treatment:

"P4: ... basically where I was there was sort of other stuff looking at, um, you know my my background and what what effect my drinking... had had on family, friends and and work..." (P4: 19-23)

The problem with this generalist approach which has, traditionally, relied on the professionalism of clinicians for its formulation is that, whereas P4 left treatment feeling like "*every day was my birthday*" (P4: 24), his excitement soon wore off and the *comparator* returned. His relapse began when he started to challenge the diagnosis and treatment provided by professional clinicians:

"P4: ... I started thinking about the unmanageability of my life and I thought well it can't have been that unmanageable? You know, I've been running a successful business, I'd never been to prison, I'd never been arrested, my wife left me but she came back very quickly, the kids were again talking to me, um, I wasn't in financial trouble..." (P4: 57-60)

Having scant in-put into his treatment process, P4 felt pressured into complying with an intervention where his own definition of an "alcoholic" differed from that of his professional clinicians and, therefore, his treatment did not specifically match his needs. This miss-match between diagnosis, treatment and a personal self-construct, I believe, is the basis for many relapses. From P4's frame-of-reference an "alcoholic" was someone who could:

- not run a successful business
- had been arrested
- had been deserted by his wife and children
- and was in financial trouble

so that, as these had not featured in his life, *quod erat demonstrandum*, P4 could not be "alcoholic" and hence he relapsed. In his case he was testing a theory which had been, clinically, superimposed upon him.

In fine, I suggest that the ATRF's diagnostic labelling and treatment interventions fail to yield more positive results, as the ATRF acknowledges (e.g. Emrick and Hansen, 1983), because though based on empirical findings which satisfy the demands of current ATRF research, they have, understandably, followed a generalist or utilitarian approach to treatment which, by nature, has ignored the complexity of divergent experience. However professionally well considered, one size of diagnostic label and treatment cannot fit all.

2.3 <u>The rôle of research into relapse</u>

I now discuss the rôle of a client in research and how I feel current clinical research attitudes tend to minimise the uniqueness of an individual. It is this belief which supported my decision to deploy, congruently, the PCA in both in data collection and analysis in a similar fashion to any person-centred intervention.

Qualitative research involves the analysis and interpretation of data (McLeod, 2011) and, in this respect, my study is no different. I am not hostile to methodologies, which seek to create substantive theories of relapse (e.g. grounded theory) or identify a commonality of phenomenological themes (e.g. IPA). But neither of these approaches

formed part of my study and my concern remains that, the power dynamic between researcher/participant is weighted, in these instances, towards the expertise of the researcher and so findings are not fully co-constructed or viewed through the eyes of the participants. In other words, they may tell half of the story.

To date, those methodologies employed by the ATRF have, by its own admission, failed to illuminate the rôle of relapse within sustained-recovery (Laudet et al., 2014) and that any conclusions reached, concerning relapse-prevention, continue to have little effect on reducing relapse rates (Yates, 2012). I agree with Vaillant (1980: 18) that current addiction/relapse-prevention treatments appear no more effective than the "*natural healing process*."

As a clinician, reliant on empirical research to support clinical interventions, justifying their continued use is made difficult if such research is, in fact, speculative or hypothetical (e.g. Marlatt and Gordon, 1985) and increasingly unjustifiable if they do not work (Allsop et al., 2000). The fact that research, especially when funded (Cheek, 2000), is driven by the needs of insurance companies/stakeholders to optimise their appropriate use of resources (Schuckit et al., 1993) means that findings are generalised as being applicable to a wide spectrum of addictions and levels of severity, without any long-term evidence of what works (Nielsen, 2003). Consequently, this utilitarian approach means that the ATRF has chosen to believe that its research-based diagnostic and treatment methods are, broadly, acceptable as they apply to a general population, thus taking a fatalistic view of alcoholism as being a hopeless cause (Mann, 1994).

My decision to engage with AA affiliates and my use of a collaborative research methodology (see Chapter 6) reflects my disquiet regarding the privilege of the professional researcher as being "expert" (Vrecko, 2010). I extend this to the apparent refusal by the ATRF to engage in any meaningful or consistent way with "lay" alcoholics (which includes members of AA) who, as "*experts by experience*" (Slade et al., 2012: 353), successfully manage to live in sustained-recovery; this borders on the discriminatory (Kidd et al., 2015).

This latter charge is to highlight the effective dismissal, in my opinion, of a large body of experience and knowledge, inherent in recovering-alcoholics currently affiliated with AA. Many of them enjoy relapse-free, sustainable recovery (Kelly et al., 2009) but

are marginalised (Schomerus et al., 2010), if not actively excluded from the debate, due to the incorrect assumptions that AA is:

- cultish (Bufe, 1991)
- empirically unsound (Ferri et al., 2006)
- has a perceived need for God-consciousness (Magura, 2007)
- an unflinchingly negative view of relapse and a corresponding demand for abstinence (Best et al., 2010)
- or that alcoholics have gained some measure of success but, irksomely, without professional help (Vaillant et al., 1987).

Conversely, when attending AA's open-meetings, as a clinician, I have only heard stressed the need for abstinence and a fear of relapse due to the fact that many, who return to drinking, die as a result.

Consequently, throughout my descriptive analysis of the data, I have tried to keep the level of my inductive reasoning to a minimum by my use of the felt-sense (see Chapter 9) and allow the participants to speak for themselves. In using the PCA methodology, I am not challenging established research methods, but present an alternative approach which defers, uncharacteristically perhaps, to the experiential expertise of the participants and attempts to view relapse/recovery through their eyes, whilst attending to their subjective perceptions of relapse as expressed through their own words. As noted above, I recognise how researchers and clinicians seek to construe alcoholism may be very different from how alcoholics view their problem (Walters and Gilbert, 2000). My rôle as a PCA researcher/practitioner was, primarily, to assist them in symbolising, with accuracy, their narrative descriptions and so I re-present my findings as descriptive vignettes of subjective experience.

2.4 Chapter Summary

The ATRF uses participant data in the belief that a researcher's inherent, professional expertise will be sufficient to analyse and interpret it in the service of its research-goals. It is this which informs practice. Given its apparent lack of success in understanding and treating alcoholism/relapse I question this attitude. By contrast,

the PCA is a philosophical approach which permeates a practitioner's life. It is connected to the phenomenological paradigm but, by paying close attention to their frame-of-reference, in attempting to view experience through their eyes, does more than *give voice* to its participants. I suggest that if it is to be deployed congruently, it has to be used, consistently, across all aspects of the research process. (A reflexive summary of my experiences of the research process, as it has affected my current understanding of relapse, is included in Appendix 15).

3.0 Chapter Three: Literature Search

This chapter details the ten incremental stages of my year-long literature search and the development of my understanding of the ATRF's conclusions and methods of studying relapse from alcoholism. I intentionally defer, until Chapter 4, a review of the ATRF's phenomenological approaches and studies which purport to focus on lived-experience, as I wish to treat these as a specific line of enquiry.

3.1 Introduction

This section aimed to create a literature search/review which, given the qualitative and phenomenological nature of my study, followed a correspondingly phenomenological approach (Moustakas, 1994; Greenhalgh and Peacock, 2005). My knowledge of relapse was restricted, being derived from my clinical-practice and working within a single psychiatric hospital (Philips and Pugh, 2005), my objective was not only to broaden my personal understanding of the phenomenon but, simultaneously, demonstrate how that understanding had emerged and matured through the iterative search process (Randolph, 2009). This would help refine and contextualise my research question (Petticrew and Roberts, 2006). Finally, the search would ascertain whether my particular line of inquiry had previously been addressed, helping to confirm both its originality and necessity (Holloway and Walker, 2000).

The literature search papers reviewed (see Chapter 4) indicated that the ATRF relies on a coterie of seven methodologies, primarily observation/cross-sectional and prospective/longitudinal or phenomenological approaches (heuristic or case-studies to a lesser degree), from which it derives hypotheses, often lacking in rigour, which are then, vicariously, applied across all addictions (Kelly et al., 2009). This may have been deemed appropriate for current research purposes, due to its use of persons within treatment-settings and operational issues of cost and ease of access (Roehrich and Goldman, 1993).

An unfortunate concomitant is that clinical treatment-settings impose artificial research schedules and devise artificial assessment-tasks for participants to perform, often wholly dissimilar from real-life situations and are, therefore, likely to yield

artificial or biased results (Ludwig and Wikler, 1974). Additionally, they tend to address only the prodromal or matutinal stages of recovery.

3.2 Theory pertaining to literature searches

Exponents of psychotherapeutic research methods (e.g. McLeod, 2003; Timulak, 2005) note that the terms literature *search* and *review* are easily conflated, though containing suggested methods for both. I am making a distinction between *search* (i.e. the gathering of data relevant to my particular study) and *review* (i.e. the subsequent critical appraisal of the same). My study is phenomenological and I agree with Hycner (1985) who suggests that the phenomenon should dictate the methods of research and not *vice versa*. I acknowledge that the binary difference between *search* and *review* became increasingly blurred as my study progressed because my review of the literature influenced my on-going searches.

In literature searches, Bates (1989) suggests a process of "berry picking" or an evolving accumulation of knowledge, where new information forms the basis of an iterative exploration of different lines of enquiry; consequently, the search itself becomes phenomenological. She suggests, this improves upon (and avoids) an over-reliance on the classic, inflexible information-retrieval model, i.e. searching selected databases yielding finite, time-bound outcomes. Perhaps less efficient than protocol-driven research strategies, it is supported by Greenhalgh and Peacock (2005), who advocate this phenomenological approach as being more comprehensively robust, especially where the evidence is complex. As an appreciation of the phenomenon gradually emerges during the several stages of the literature search (Randolph, 2009), this development should be made evident (Greenhalgh and Peacock, 2005). Refinements in understanding, in turn, refine the research question (Petticrew and Roberts, 2006).

3.3 My approach

Believing that my overall knowledge of the ATRF's alcohol research was narrow, my search aimed to broaden that understanding (Philips and Pugh, 2005) and, secondly, to discover whether my particular line of inquiry had been previously addressed

(Holloway and Walker, 2000). The several stages of my iterative process culminated in a formal literature review (see Chapter 4). At each stage of my search, my findings were documented in individual papers submitted to my supervisory team.

Bates (1989) further advocates the use of a journal run (i.e. searching through key journals). I used this comprehensively within my study. 79 of the most frequently cited journals (drawn from the reference sections of all papers read) were subjected to two manualised literature searches. Commencing in 1960 (Jellinek's seminal codification of alcoholism as a disease) to March 2017, these journals were searched by individual issue, month and year in two stages; September/October, 2014 and repeated between the 9-20th January, 2017. The first manual search widened my perception of the phenomenon and the second confirmed that my research had not been replicated.

The robustness of the literature search was enhanced by extending the "berry picking" approach (Bates, ibid) outside academic reports and journal articles. The diversity of my search strategies included:

- *Classical bibliographic and abstract searches across seven databases*: PsycARTICLES; PsycINFO; MEDLINE; MEDLINE with Full Text; SocINDEX with Full Text; Academic Research Complete; CINAHL (Cumulative Index of Nursing and Allied Health Literature) Complete
- *Area scanning* (browsing articles located under the same or similar subject headings)
- *Journal run*: a search was made of 79 complete journals from 1960 to the present day. Papers which referenced the terms alcoholism; recovery; relapse; Alcoholics Anonymous; or lived-experience were printed in full
- *Footnote/reference chasing*: (following up footnotes which seemed relevant) reference lists in each paper retrieved were scanned for other complimentary articles; this continued throughout the course of the study
- *Citation tracking*: (identifying papers which had cited other articles of interest) this was done manually through *Google Scholar* and through the University's interlibrary loan facility

- *Author run*: (e.g. the papers of W. L. White) literature searches were made against all the main authors on alcoholism/addiction studies
- *Subject searches:* in bibliographies and indexing and abstracting services (e.g. the UCLAN *ebrary* service)
- *Personal knowledge and resources*: I attended, annually, meetings of the United Kingdom, European Symposium on Alcohol and Drugs (UKESAD) and The Society of Analytical Psychology (SAP). Authors were contacted within the ATRF and I accessed the knowledge of my clinical colleagues at the Priory Hospital where I worked. I attended training courses for other addiction treatment modalities. This allowed additional sources of information and lines of enquiry to emerge
- *Grey Literature*: particularly autobiographical accounts of recovery from alcoholism and other addictions
- *A pilot study*: to test the feasibility of the research (see Chapter 7).

Each linear stage of my literature search is now described, detailing the method, findings and a summary in each case.

3.4 Stage One (January, 2014)

3.4.1 Method

Following Orford's (2012) hypothetical simulacrum of a *family-in-distress-seeking-information*, I commenced my search by entering the following, generalist phrases in the search engine *Google*: "*relapse and alcohol*"; "*statistics for alcohol relapse*"; "*family response to relapse from alcohol*"; "*triggers for relapse*"; "*predictors of relapse in alcohol*"; "*reasons for relapse*"; "*motivation to stay sober*". I avoided the terms "*alcoholic*" or "*alcoholism*" being predetermined labels resulting from clinical diagnosis.

Excluding advertisements for rehabilitation centres or sites advocating specific treatment modalities, the first 10-15 responses were reviewed. I sought to discover

how a lay person's understanding of such phenomena might be informed, when using this popular source of information-gathering.

3.4.2 Findings

Relapse (equally labelled a *slip* or *lapse*) was characterised as being attributed to alcoholism, an incurable illness affecting the brain's neural circuitry. Alcoholism was a persistent, chronically relapsing condition (*psychologytoday.com*) and, therefore, risky but relapse served as a learning-experience (*drink-aware.co.uk*). Though rarely achieved, its only antidote was abstinence. Relapse was precipitated by *triggers* or *cues* (termed *craving*), being responses to negative life-events, predominantly caused through *stress* (*alcoholic.org*). Identifying and predicting triggers were essential, as recovery involved maintaining psychological health and well-being, through developing adequate *coping-strategies*. Craving was alleviated by prescribed medication. Alcoholism brought with it social *stigma* (*breakingthecycles.com*).

3.4.3 Summary

There was no consensual description of relapse, but key phenomenological themes included: alcohol; alcoholism; triggers; cues; recovery; illness; craving; and stress (all equally ill-defined). These were proffered as salient to understanding the phenomenon of relapse. These themes formed the search-terms of my subsequent literature searches.

3.5 Stage Two (March, 2014)

3.5.1 Method

I addressed the characterisation of alcoholism being an *illness*. Using search words *alcoholism* AND *relapse* AND *craving* AND *stress* AND *recovery* (gained from Stage One) a search was made (22.3.14) of the bio-medical search engine *Wiley on Line*. This sought to understand how these phenomena were viewed or inter-related within the ATRF's bio-medical field and how alcoholism was conceptualised as an illness. Of 624 articles searched 44 were found directly relevant.

3.5.2 Findings

Papers suggested that although relapse-prevention research had emerged as the single most important focus for the addiction-treatment (Marlatt and Gordon, 1985), high rates of relapse remained unaffected (Allsop et al., 1997). The ATRF's bio-medical arm viewed all types of addiction as being genetically-conditioned, relative to how a substance was processed and experienced, contributing to whether or not a person would continue to ingest the substance compulsively, resulting in neuropathological changes (Ducci and Goldman, 2008). It combined learned-behaviour, psychological dysfunction and disturbed neurobiological functioning which, in the case of *alcoholism*, was described as: a cycle of acute intoxication; tolerance and reinforcement; withdrawal and consequent dysphoria; craving; compulsive-use; and repeated attempts to stop (Weiss et al., 2001; Cami and Farré, 2003; Koob, 2006).

Stop-attempts appeared to be synonymous with *relapse*, but there existed no consensual definition of addiction, craving or relapse, which could be construed in terms of biological, social or psychological processes or some combination of all three (West, 2001). *Stress,* however it was subjectively perceived or as a response to external stimuli, was regarded as the primary cause of both alcoholism and relapse (Sinha, 2001). Consequently, relapse was labelled a phenomenon of altered brain-chemistry, with neuroadaptations to negative and positive affect (i.e. stress or reward) expressed by the phenomenon of *craving* (Fox et al., 2007).

As an epiphenomenon of addiction, *craving* highlighted a mal-adaptation of brain-reward-circuitry manifested by significant urges to engage with a drug, despite negative consequences (Weiss, 2005), potentially indicating sustained cognitive impairment (Bates et al., 2002). Reducing *craving* was, confidently, interpreted as a significant treatment-outcome variable (Littleton, 2000). Neuroimaging techniques highlighted the brain's response to mental cues, stimulating urges to drink (Drummond, 2000). Consequently, neuroimaging was increasingly employed within biomedical research (*post* 1990 when the technology emerged) having radically altered the way in which alcoholism (and other substance-use) was conceptualised as being a neurocognitive illness (Goldstein and Volkow, 2002).

Addictive drugs were not analysed/researched individually, but under the broad *aegis* of *substance-abuse* (Schaub and Dossey, 2000). This posited that what described one drug described all (Cook and Reuter, 2007), in so far as drugs affect underlying mechanisms of dependence (West and Gossop, 1994), with minor differences for cannabis and types of amphetamine, which inhibited dopamine release (West and Gossop, ibid). This mirrored social perceptions of drug and alcohol-use, as being one-and-the-same (Pittman, 1988).

This *aegis* approach applied, equally, to suggested precipitants of relapse (Havassy et al., 1991). Understanding the rôle of craving and stress, as precursors to renewed drug- or alcohol-use, was significant. Via animal experimentation, triggers were explained in the bio-medical context of the mechanisms of their respective processes (Fox et al. 2007). How these phenomena unsettled an alcoholic by threatening controlled-drinking or abstinence was unclear, because animal experimentation could not reveal underlying emotional states, (i.e. whether relapse was a conscious/volitional or unconscious/involuntary act), but did illuminate physiological functioning (Miller and Goldsmith, 2001). Stress and craving were integral to relapse affecting treatment-outcomes, but appeared to be uniquely personal constructs (Vaillant, 1995). Alcoholism was delineated as a *chronic-relapsing-illness*, implying that improvements in social and psychological functioning, brought about by pharmacological agents, were only short-lived (Becker, 2008).

3.5.3 Summary

Bio-medically, addiction appeared genetically conditioned where relapse resulted from altered brain-chemistry, affected by stress and craving. Although alcoholism was construed as a chronic-relapsing-illness, human experiencing of any drug's effects was not replicable within the laboratory. The bio-medical chances of longer-term recovery appeared bleak and unhelpful to my study's purpose. I sought, therefore, to understand the corresponding psychosocial perspective and its treatment-outcome goals.

3.6 Stage Three (May, 2014)

3.6.1 Method

In May, 2014, I attended the UK/European Symposium of Addictive Disorders (UKESAD). The keynote speaker was Prof. John Kelly whose talk, "*Empirical Awakenings: The new science on mutual-aid, and clinical interventions to facilitate its use*" provided a psychosocial perspective, particularly as regards the healthcare cost/offset potential of using mutual-aid groups (e.g. AA) in securing improved treatment-outcomes. As my study's participants would be AA affiliates, I reviewed the references from his talk.

3.6.2. Findings

Alcoholism/addiction possesses neurobiological components, but could be successfully treated *psychotherapeutically*, via cognitive/behavioural alterations to the personality, augmented by long-term support from mutual-help groups, such as AA (Kelly et al., 2009).

However, such groups are marginalised, their utility being historically called into question (Bufe, 1991) because of a lack of professional status ascribed to them by an ATRF, which demands empirically-based research-outcomes (Kelly, et al., 2002). The problem is not what mutual-help groups do, rather how they are, professionally, perceived (Kaskutas, 2009). Addiction clinicians struggle with AA's model of alcoholism (i.e. a tripartite malady of body, mind and spirit), for which only a spiritual rejuvenation can effect lasting change (AA, 1976).

Citing Walitzer et al., (2009), Kelly suggested that AA (like other mutual-help groups) materially influenced the outcome of addiction-treatment and long-term attenuation of relapse and there existed a growing body of empirical research substantiating this claim (Donovan et al., 2013). Founded in 1935, AA boasts a worldwide membership of several million persons (Laudet, 2008a) and assists in maintaining abstinence-based recovery *for some people*. Precisely how this is achieved was unclear (Krentzman et al., 2010), hence it was not fully incorporated within mainstream treatment.

The ATRF was principally interested in mechanisms of change (Magura et al., 2003); how a person moved between addiction and recovery (Kelly et al., 2009); and, once

having effected that transition, how recovery was maintained (Prochaska and DiClemente, 1982, 1983, 1984, 1986). The increasing demand (by some addicts) for a recovery/abstinence-based lifestyle differed, markedly, from the pragmatic, harm-reductionist approach advocated by some quarters of the ATRF (Laudet, 2008) which was antithetical to total abstinence (Lee et al., 2011). Despite their unprofessional aura, the potential for mutual-help groups to secure and maintain abstinence was becoming, increasingly, important (Kelly et al., 2011).

3.6.3 Summary

My search revealed two wings of the ATRF whose assessment, diagnosis and treatment of alcoholism might have differing treatment-outcome goals. Given my own clinical diagnostic procedures, I wanted to understand how the ATRF advocated the diagnosis of alcoholism, thereby determining what constituted a positive-outcome and any rôle relapse may play within this. This seemed important in view of the changes being made to a key utilitarian diagnostic tool, the Diagnostic and Statistical Manual, (DSM 5), which came into effect in 2013 (APA, 2013).

3.7 Stage Four (June, 2014)

3.7.1 Method

I conducted a journal-run of a leading research journal, *Addiction* using CINAHL (2000-2014). This demonstrated how one journal reported the debate surrounding the planned changes to DSM 5 and detailed how these might affect assessment and outcome goals.

For comparison, PsycINFO and PsycARTICLES were searched between 1990 (the inaugural date of biomedical advances in brain neuro-imaging techniques) which confirmed or made moribund previously observed behavioural hypotheses regarding the addictive process and 2014, the date of this search.

PsycINFO was searched using the Boolean/Phrase; *addictions*, OR *assessment*, OR *primary outcomes* OR *diagnosis of substance abuse* AND *treatment effectiveness*. Subject: Major Heading was limited to *alcohol-abuse* and *drug-abuse* and the

Classification of *substance-abuse and addiction* and *drug and alcohol rehabilitation*. 63 articles were found of which 6 were relevant.

PsycARTICLES was searched using the Boolean/Phrase *alcoholism*, OR *assessment methods*, OR *outcome measurement*, OR *diagnosis*, AND *treatment effectiveness.* This was similarly limited between 1990 and 2014, with the Subject Heading, *alcoholism* and Classification of *substance-abuse and alcohol*. 198 articles were found of which 27 were useful.

3.7.2 Findings

Brown (2004) argued that DSM criteria positioned relapse within the process of accurate diagnostic assessments of an individual's personal characteristics and his/her general matching to treatment, which aimed to improve treatment-outcomes. Located within a broad *aegis* of addictions (Castonguay and Beutler, 2006) relapse could imply:

- a lack of a treatment-modality's efficacy (Castonguay and Beutler, ibid)
- an alcoholic's lack of motivation (Prochaska and DiClemente, 1984)
- or reinforced the bio-medical belief that relapse was inevitably part of the alcoholic condition (McLellan, 2002).

The difference between DSM 5 and its prior manifestations lay in its terminology (NIAAA, 2013). DSM diagnosis was non-specific, covering a general population with a wide continuum of alcohol severity (Dawson et al., 2007). Previously, DSM-IV (APA, 1994) described alcoholism as constituting two distinct disorders (abuse and dependence) with specified criteria for each. It replaced "addiction", a word fraught with negative stereotypes and connotations, with "dependence" providing a less moralistic and stigmatising language when discussing addiction (O'Brien, 2011). However, this could obfuscate the distinction between the 21st Century's normative concept of addiction, as denoting *harm* and mere physical *dependence*, connoting neuroadaptations, leading to tolerance and withdrawal, which may not entail *harm* (Wasmuth et al., 2014).

DSM 5 integrated these terms, conflating *substance* dependence and *physical* dependence, thereby defining addiction as *substance-related and addictive disorders*,

(SUD's) which it categorised by drug-type (O'Brien, 2011). Henceforth, alcoholism became *alcohol-use-disorder* (AUD) with each disorder possessing varying levels of mild, moderate and severe use (APA, 2013). DSM 5's diagnostic thresholds similarly changed and there now existed eleven distinct criteria (it omitted DSM-IV's legal problems), cataloguing the effects of ten different drugs (described in neurobiological terms). A person's level of severity was determined by the more criteria met, within a twelve month period (APA, 2013).

Reflecting its advancing knowledge surrounding the neurobiological underpinnings of addiction, especially dopamine release (Volkow and Baler, 2013) which elicits the observable phenomenon of increased "wanting" (Berridge, 2007), DSM 5 admitted additional substances (e.g. cannabis, caffeine and tobacco) and behaviours (gambling) as being addictive, as well as the phenomenon of *craving* as a contributory factor of relapse. Nonetheless, DSM could not be viewed as more diagnostically precise than its forbears, as both relied on subjective self-reporting (i.e. an addict's narrative-account of the problem) (Babor, 1986), often shaped by his/her self-perception (i.e. how s/he defined the experience) (Robak, 2001), comprehensively mediated by the interpretative judgement of the diagnosing clinician (Wasmuth et al., 2014). After all, not all drug-users, even matching many diagnostic criteria, became addicted (O'Brien, 2008).

However, there remained no consensus regarding diagnostic techniques for assessing the level of alcohol severity (Polcin, 1997). Equally employed, was the International Classification of Diseases (ICD-10) (WHO, 1990) which split addiction into three categories:

- acute intoxication (i.e. single or multiple episodes)
- harmful-use (i.e. more frequent use)
- dependence.

Whilst individuals might experience any or all of these patterns of drinking, within their drinking life-style, the heterogeneous nature of the alcohol phenomenon rendered it virtually impossible, to develop robust diagnostic categories of alcohol-abuse or dependence that were mutually inclusive or exclusive (Hedblom, 2007).

If diagnosis was problematic, then matching a person to appropriate treatment became more so (Babor and Del Boca, 2003) which, consequently, prevented the definition of what might be regarded as a successful outcome (Castonguay and Beutler, 2006).

Consensus on clinical outcomes was hindered, *inter alia*, by a combination of:

- the lack of standardisation of drink measurement and published drinking guidelines, which differed between countries (Kaskutas and Graves, 2000)
- the diversity of interventions and consensus on outcomes which varied from: total abstinence (Donovan et al., 2012); percentage days abstinent; drinks per drinking day; number of heavy drinking days; presence of alcohol-related problems; dependence symptoms; and biological markers of drinking (or heavy drinking) to verify an individual's self-report and which could be integrated with reports of others (Litten at al., 2015)
- arguments for separate specialist treatment assessment protocols for differing individuals who, nonetheless, shared vaguely similar sociodemographic characteristics (Robins et al., 1988)
- the differing perspectives of the research investigator, practitioner, drug-user or policymaker (Miller, Strang and Miller, 2010)
- whether the chosen intervention focused on single or poly-drug-usage, which could reflect the purported specificity (versus the generalisablity) of treatment effects (Babor et al., 1992)
- the validity of individual self-report in describing drinking behaviour which was viewed as either reliable (Fals-Stewart et al., 1995) or wildly inaccurate (Magura, 2008).

The ATRF's failure to define craving (Rohsenow and Monti, 1999) rendered its inclusion, within DSM 5's diagnostic criteria, potentially impotent. Treatment-outcomes could signify an improvement in quality-of-life, but uniquely personal constructs could include aspects of individual perception (including the ability to drink) unrelated to the treatment modality being used (Tiffany et al., 2012). Indeed, more people with alcohol problems resolved their difficulties and improved their quality-of-

life themselves, without accessing formalised treatment (Cunningham and Breslin, 2004).

The sharpest disagreement centred on whether abstinence was a pre-requisite of outcome (Donovan at al., 2012) or whether relapse should be tolerated (Tiffany et al., 2012). If recovery, (i.e. abstinence) being both time and experience dependent, (Roehrich and Goldman, 1993) was to serve as a meaningful treatment-outcome measure, should it be judged by a binary abstinent/relapse construct, or as a multifaceted process (Schneider et al., 1995)? If so, then there needed to be some collegial agreement as to whether abstinence was a realistic, proximal, treatment-outcome goal or not (Rahill, et al., 2009).

Del Boca and Darkes (2012) suggested a *via media*, harmonising these two positions by distinguishing between primary-outcomes (substance-use indices) and secondary-outcomes (other benisons associated with alcohol cessation). Their view, based on the conceptualisation of addiction as a pathological distortion of the human motivational system (Robinson and Berridge, 2001), suggested that both consumptive behaviour (Donovan et al., ibid) and proxies for motivation, or craving (Tiffany et al, ibid) could be amalgamated.

Others regarded addiction as, simply, an incurable brain disease (Gartner et al, 2012), so that preventing relapse, by exercising personal self-efficacy, appeared meaningless (Samson, 2000). AA shared this view (including somatic and spiritual/experiential aspects of the malady), so that proximal outcomes (i.e. complete cessation) were paramount. Kalivas and Volkow (2005) suggested addiction was an impaired response inhibition to an intense desire for a drug or, more ubiquitously, a chronic-relapsing-disorder characterised by:

- a compulsion to seek and take a drug
- loss-of-control in limiting its intake
- and finally, the emergence of a negative emotional state (e.g. dysphoria), when access to the drug was prevented or denied, termed dependence/withdrawal (Koob and Le Moal, 1997).

Outcomes were regarded as a mixture of both proximal and distal gaols depending on the philosophy of the modality, patient autonomy and the attitude of society (Weiss, Griffin and Hufford, 1995).

The Substance-Abuse and Mental Health Services Administration (SAMHSA) defined recovery as a process of change, through which a person achieved abstinence, leading to improved wellness and quality-of-life (White, 2007). McKeganey et al., (2004) reported that there was a positive relationship between these two elements and that this was being expressly desired by alcoholics/addicts so that continued and prolonged abstinence was reflected by better quality-of-life (Foster et al., 1999). Furthermore, quality-of-life satisfaction (at the end of outpatient treatment) provided both a key predictor of commitment to abstinence and a strong indicator of sustained-abstinence (Laudet and Stanick, 2010). Unfortunately, despite its utility in assessing dimensions of recovery, measuring such satisfaction remained uncertain (Hibbert and Best, 2011) being confined to study-populations at the initial stages of recovery (Foster et al., 2000).

3.7.3 Summary

DSM 5 did not appear to have improved clinical diagnosis significantly. Relapse affected treatment-outcome, but there remained no consensual definition of what it might be and the prevailing *zeitgeist* of a particular modality could allow for future consumption.

3.8 Stage Five (June, 2014)

3.8.1 Method

I broadened my search, following the search strategy of Bates (ibid), to include books containing chapters on relapse. In June, 2014, I made a manual search of the UCLAN library catalogue using the word *alcoholism*. The first 200 of the 1255 books (and e-books) listed were reviewed; 22 were germane to this study. However, no book reviewed, described the lived-experience of alcoholism/relapse *per se*, but focused on the psychosocial and biomedical aspects of treatment.

3.8.2 **Findings**

Library literature and research papers evinced a corresponding attitude within the ATRF towards relapse, alcoholism and its treatment methods. In-patient treatment followed a sequential and relatively generic pattern:

- identification of the problem
- referral or "matching" for treatment
- the agency's response, via its programme, to an individual's needs
- the treatment process, based on a particular treatment modality (non-compliance here being an indicator of potential recidivism)
- rehabilitation, assessed via an individual goals and needs
- treatment maintenance, monitoring and aftercare, (goals could be changed where needed)
- and finally termination and short-term follow-up when goals had been reached.

This was an advocated, standard, formulaic treatment of addiction (Arfken et al., 2003).

Relapse was embodied within the overall understanding of the addictive process, though that process and what delineates an "alcoholic" (in terms of severity and social, physical and psychological consequences) was not consensually clear (Connors et al., 1996). "Alcoholic" was a generic label or typology of personality to distinguish someone whose drinking was causing problems to themselves and their wider social environment (Cloninger, 1987). The books' main identifiable themes were:

1) ***Defining addiction:*** Beyond DSM 5 and ICD-10 there appeared little agreement as to how this could be achieved with any degree of exactitude (Hedblom, 2007).
2) ***Predicting relapse***: This was the primary pre-occupation for the ATRF (Abraha and Cusi, 2012), an alcoholic and his/her social environment (McLellan and McKay, 1998). The wider aim of prediction was not to identify variables which determined whether a person would drink or not, but the assessment of those specific conditions under which relapse was likely to occur. Relapse, as well as excessive alcohol-use, was a major societal problem (Plant and Plant, 2006).

3) ***Preventing relapse/Learning skills to avoid relapse triggers:*** Prevention and treatment were synonymous, both aiming to head-off relapse (Allen and Anton, 2003). Alcoholics and non–alcoholics, demonstrated little difference in interpersonal problem-solving competencies, but an alcoholic's reduced inhibitory abilities (i.e. their "typical" drinking response to problems) meant that s/he needed to learn coping-skills (Sher et al., 2009), accompanied by prolonged motivation to maintain them (Harrison, 1995). Higher recovery maintenance was linked with greater commitments to abstinence and the avoidance of high-risk situations. Relapse prevention was specifically, "*the more formal activities that are designed to prevent "slips" or "lapses" from leading to full-blown relapse—that is, a return to the individual's pattern of drinking before treatment*" (Institute of Medicine, 1990: 69).

4) ***Treatment matching***: Matching a realistic problem-severity-to-service proved elusive, especially where a person experienced comorbidity of symptoms and/or poly drug-use. Here the *aegis* approach (of treating all drugs as being the same) created problems (Babor and Del Boca, 2003), because people using different drugs or experiencing varying comorbidities did not respond (with equal effectiveness) to all treatment modalities (Castonguay and Beutler, 2006).

5) ***Variables which may precipitate relapse:*** The plethora of confounding variables affecting relapse was seemingly limitless (Castonguay and Beutler, 2006). Since the 1980's, relapse had sat, squarely, within the purlieu of a taxonomic schema of treatment and outcome, where outcome was not unidimensional but incorporated many aspects of a patient's pre- and post-treatment lifestyle: e.g. job, family relationships, financial security, etc., (Institute of Medicine, 1990a). These could affect relapse indicating their salience as targets for relapse prevention (Foss et al., 2002). Pre-treatment symptom severity was cited as an outcome-treatment-variable (Annis and Davis, 1987), but other variables included craving and feelings of being unable to cope (Hedblom, 2007). However, Vaillant (1995: 222) argued that many variables of relapse were unimportant, suggesting that, "*an alcoholic's craving is best understood as a verbal ex post facto rationalisation of conditioned behaviour*".

These five domains appeared to dominate the psychosocial treatment of alcoholism (Harrison, 1995). The heterogeneous range of confounding variables, affecting treatment-outcome, broadened the scope and complexity of post-treatment evaluations. However, to reduce ambiguity surrounding the make-up of "aftercare," the ATRF rebranded this area to include, follow-up, continuing care and relapse-prevention (Harrison, ibid).

Broadly speaking, treatment procedures (post-detoxification) were euphemistically identified with relapse-prevention strategies. Such strategies based on research undertaken by Litman (1986) and her "survival" model and Annis's (1986) self-efficacy approach, derived from Bandura's social-learning theory of self-efficacy (Bandura, 1977, 1982, 1986). In short, the acquisition of alcoholism was as a defensive coping-tool and that recovery or relapse attenuation was possible, where a person learned adequate coping-skills.

This culminated in the seminal Relapse Prevention Model (RPM) of Marlatt (1985) which prized the development of personal self-efficacy to resist triggers, occasioned by high-risk situations. Self-efficacy involved identifying contexts, particularly the antecedents, in which a person drank (Marlatt and Gordon, 1985). This determined areas of high-risk and a person's feelings of confidence in his/her ability to handle conflictual or stressful drinking situations, without resorting to heavy drinking. The key assumption was that relapse originated within a person's meaning (*expectancy*) attached to the act of drinking, serving as the lure to recidivism and not his/her habitual drinking, which had resulted in chronic consumption (Marlatt, 1988).

The RPM measured, via the Transtheoretical Model of Change (TMC) (Prochaska and DiClemente, 1984), patient motivation and commitment to maintain those gains which treatment afforded. Despite its dominance within the ATRF's psychosocial wing, the RPM's efficacy was challenged (Longabaugh et al., 1996) as replication of its initial results had not been achieved (Lowman et al., 1996). It was viewed as promoting an over-reliance on the learning of coping-skills; concentrating purely on antecedents of relapse; and failing to establish the predictive nexus between urges-to-drink and relapse (Madden, 1996), or the expectancy of a beneficial effect and the negative consequences which followed (Maltzman, 2008).

The ATRF's psychosocial arm was staking an hegemonic claim into the successful treatment of alcoholism (Pryce, 2006), reliant on an empirically-based intervention which claimed effectiveness with all addiction types (Huebner and Kantor, 2011). This surmised that relapse was under the control of a consciously *functional-self* and could be cognitively assessed and behaviourally altered. It also followed a, "*more is better''* approach (Barr and O'Connor, 1985), wherein should relapse occur, an alcoholic needed only to develop more self-understanding and learn more coping-skills.

The ATRF presented a difference of conceptualisation. The bio-medical arm viewed alcoholism as an incurable illness of the brain or neuropathology, caused through years of consumption, where relapse could be attenuated by pharmacology (Doyle et al., 2010). The psychosocial arm regarded the aetiology and acquisition of alcoholism as a treatable learned-behaviour, which could now be unlearned (Marlatt and Gordon, 1985). Relapse (or abstinence) became a matter of patient volition (and culpability). Psychotherapeutic treatment equipped a person with the skills to deal with a myriad of confounding variables/threats, (Moser and Annis, 1996), even enhancing their motivation to change (Miller and Carroll, 2006).

It appeared immaterial that no individual therapeutic modality was ever designed or equipped to tackle such a plethora of attendant issues (Castonguay and Beutler, 2006). Between 1997/1998 the ATRF embarked on its single, largest clinical trial to-date, Project MATCH (1997; 1998) in order to resolve the dispute between therapeutic modalities striving to prove their primacy in treating addictions (Timulak, 2005), by comparing the efficacy of treatment/outcome matched against patients (Babor and Del Boca, 2003). The anticipated conclusion, that professionally-run, cognitive and behavioural therapies would eclipse all other contenders, was shattered when, by a narrow margin, the 12-Step, amateur-based programme of AA was proven, longer-term, to be more effective (Maltzman, 2008).

The rôle of social-support, especially from mutual-help groups, appeared to be a significant protection against the threat of relapse (Nixon and Glen, 1995). Though, in securing stable remission, its function and that of other resources, either personal or community-based, were unclear and had, subsequently, become the subject of detailed scrutiny (e.g. Kelly and Yeterian, 2011; Kelly and Greene, 2014). That AA, which is non-professional and makes no claims to having a scientific or empirical basis,

may be all that stands between a person and relapse, once the professionally lead therapy has been completed or as the sole means of achieving sobriety, underpins my research study.

3.8.3 Summary

Defining, predicting, preventing and treating alcoholism/relapse is the main purpose of addiction-treatment. The efficacy of the RPM as the predominant means of relapse prevention is suspect. Amateur mutual-help groups appear marginally more effective for longer-term relapse attenuation.

3.9 Stage Six (July, 2014)

3.9.1 Method

I made a further manual search of the UCLAN library database using the word "relapse", without further parameters. My intention was to locate the phenomenon of addiction-relapse in a wider context, by comparing it with other chronic illnesses. There were 23 books identified (6 referring exclusively to alcoholism/addiction).

3.9.2 Findings

Relevant books were predominantly generalist, therapist guide-manuals, viewing relapse from a psychosocial perspective. Some involved addiction, both substance and behavioural, as well as dual-diagnosis (Washton and Zweben, 2006; Rassool, 2009). Additional presenting addictive problems included: compulsive hoarding (Steketee and Frost 2006); and pathological gambling (Ladouceur and LaChance 2007). Others addressed a varied range of psychiatric illnesses, some predominantly cognitive with physical side-effects:

- post-traumatic stress disorder in adolescents (Foa et al., 2009)
- depression and anxiety (Williams and Hagerty, 2005)
- psychosis (French and Morrison, 2004; Lobban and Barrowclough, 2009)
- obsessive/compulsive disorder (Freeman and Garcia, 2009; O'Connor and Aardema, 2011)
- anxiety and panic (Pincus et al., 2008)

- seasonal affective disorder (Rohan, 2009)
- and more chronic physical illnesses: e.g. coeliac disease (Griffiths 2008)
- multiple sclerosis (Coyle and Halper 2007; Birnbaum, 2009)
- multiple myeloma (Tariman, 2010)
- and, general cancers (Verrite, 2009).

Unlike addiction, relapse within chronic illnesses engendered favourable, rather than vituperative reactions. The progression and clinical worsening of a condition was sometimes preceded (or had been followed) by a stabilising plateau-period (Coyle and Halper, 2007), instead of a return to a previous state of good health or amelioration of symptomology. For example, with coeliac disease a person's modification of diet could prevent relapse, especially in conjunction with pharmacological interventions.

For other illnesses (e.g. multiple sclerosis) relapse, *per se*, was absent. Triggers to relapse might be identifiable or open to diagnosis but not, necessarily, avoided (Tariman, 2010) and thus proved inevitable. Accordingly, there was no moral censure or implications of personal blame as regards the patient's compliance with treatment or initiation of the illness (Kent, 2001). Despite the fact that alcoholism/addiction was viewed as chronically-relapsing, mercurially, no evidence was proffered which suggested that it was more relapse-prone than other chronic illnesses (Cunningham and McCambridge, 2012). However, by implication, alcoholics and other addicts relapsed due to some form of deliberate intentionality, not found within other illnesses (Perkinson, 2004).

With pharmacological agents, relapse could be arrested or the progression of the illness slowed, minimising or ameliorating the patient's primarily physical condition. Pharmacology addressed withdrawal (e.g. benzodiazepines), dependence (e.g. opioid antagonists) or specifically relapse-prevention (Abraha and Cusi, 2012). Relapse was located, therefore, in relation to the advance of the illness and its recurring symptoms. Relapse did not happen without reason (Ladouceur and LaChance, 2007) and was an actual event in time, yet a distinction was made between a temporary lapse or slip, used as a "*learning experience*" (Boeri, 2013: 140) and a full-blown return to the illness (relapse) and its concomitant behaviours (Steketee and Frost, 2006).

For non-chronic illnesses (e.g. seasonal affective disorder) a robust relapse plan could identify triggers leading to relapse (Foa et al., 2009; Rohan, 2009). Cognitive-behavioural therapy (CBT) was championed as the therapy, *sans pareil,* in combating negative thoughts, although the social support of 12-Step recovery programmes was significant (Boeri, 2013). Motivational Interviewing Therapy (MIT), strengthening a person's resolve in maintain recovery, was also useful (Kent, 2001). With time and practise, negative symptoms could be expected to abate (O'Connor and Aardema, 2011).

Overall, addiction was a lifetime disorder of remissions and relapses, termed a "*revolving door*" (Boeri, 2013: 139), sometimes leading to premature death. Even where the illness was progressive or severe, sustained remission was possible by embracing abstinence and a "*strict and gratifying regimen of new behaviour*" (Perkinson, 2004: 179). Not all researchers favoured abstinence, preferring to conceptualise sobriety as "social recovery". This necessitated acquiring coping-skills, resources and networks which allowed a person to live within society, without resorting to problematic drug- or alcohol-use; though this was to walk a fine line between recovery and relapse (Boeri, 2013).

Relapse avoidance necessitated the psychological input of the patient. It was not suggested that a treatment modality was ineffectual, beyond a possible failure to match a patient with treatment, accepting that some modalities claimed more salience than others (Hammer et al., 2012). But, without suggesting to an individual that there were notions of personal blame, relapse could be seen as a failure, either through lack of motivation or failing to adhere to a realistic relapse-prevention strategy (Perkinson, 2004). As a phenomenon, relapse evidently happened, but was not limited to the field of addiction. However, with addiction, unlike other illnesses, relapse avoidance demanded additional effort, motivation and resources on the part of the addict (Miller and Carroll, 2006).

3.9.3 Summary

Addiction appeared no more or less relapse-prone than other chronic illnesses, yet seemed to evoke a more stigmatised response, which implied that addicts are, potentially, responsible for recidivism. Relapses were caused and could be attenuated

by cognitive-behavioural therapy (and pharmacology), but remained part of a diagnosis of chronicity.

3.9.4 Training courses (July, 2014)

In this month I attended two training courses. First, (22-23/07/14) for Motivational Interviewing/Enhancement Therapy (Miller and Rollnick, 1991) and secondly, (28-29/07/14) for Dialectical Behavioural Therapy (Dimeff and Linehan, 2008), both offering therapeutic techniques for the treatment of dependent drinking. As standalone interventions for alcoholism (and other addictions) both claimed positive results, but neither could indicate demonstrable long-term success in the attenuation of relapse.

3.10 Stage Seven (August, 2014)

3.10.1 Method

The ATRF appeared to view the theoretical conceptualisation of alcoholism through various lenses, influencing how relapse was perceived. I wanted to understand more about the theoretical underpinning of the phenomenon. In August, 2014, I searched MEDLINE, PsycARTICLES, PsycINFO, SocINDEX, Academic Research Complete and CINAHL using the key words *theory* OR *model* together with the search phrases *addiction, dependence, alcohol, drug or nicotine*. At this stage, I was still following the ATRF's aggregate view of addiction as incorporating all substances/behaviours of abuse. This yielded 103 relevant articles. As before, the search parameter was confined to between 1960 and the present.

3.10.2 Findings

Conceptualising *alcoholism* within the even broader term of *addiction* can link it with:

- loss and grief (Beechem et al., 1996)
- pleasure (Bejerot, 1980)
- compulsion (Dodes, 1996)

- attachment transition (Höfler and Kooyman, 1996)
- unconscious fantasises of homosexuality/compulsions of masturbation (Hopper, 1995)
- a form of perversion (Keller, 1992)
- self-medication (Khantzian, 1985)
- a disease (Miller and Giannini, 1990)
- a failure of self-regulation (Wilson et al., 1989)
- and a disease of compulsion and drive (Volkow and Fowler, 2000).

This first group of theories focused on the general processes of addiction in terms of behavioural, social or biological models, though I doubt that each possesses equal validity or will stand the test of time.

A second group sought to explain why particular stimuli (e.g. reward, pleasure, relief or excitement) provided a higher propensity to become a focus of addiction, so that changes in an addict meant that such effects were enhanced, becoming more relied upon. Dominant themes were the positive and negative reinforcing properties of addictive drugs (Bozarth, 1994); the toxicant-induced loss of tolerance (Miller, 1997); and the theory of incentive-sensitisation of Robinson and Berridge (1993), who hypothesised that the positive reinforcing effects of addictive drugs were potentiated (rather than diminished) by repeated exposure. This compared with the cue-exposure paradigm whereby, presenting alcohol-dependent persons with items or images associated with their alcohol-use, could induce a state of conditioned-craving (Childress et al., 1986). An alcoholic did not merely want alcohol s/he needed it, as the cue became goal-focused (Ball and Little, 2006).

A third category explored why some people appeared to be more susceptible (biochemically, psychologically, or socially) to addiction than others or more in need of the effects which drugs offered. One dominant theme was genetic susceptibility (Cheng et al., 2000), or even that there existed an addictive personality (Nakken, 1988) which could determine a person's drug of choice (Hayter, 1971).

A fourth group concentrated on environmental and social conditions, which rendered addiction/relapse more or less possible. Factors included:

- stress (Breslin et al., 1995)
- post-traumatic stress (Seidel, Gusman and Abueg, 1994)
- psychosocial stress (Brown et al., 1990)
- and, social rôles and social influences (Hajema and Knibbe, 1998).

The fifth area, being an amalgam of the other theorists, explained recovery/relapse by concentrating on the effects of withdrawal from particular stimuli (e.g. drugs or environmental influences) or analysing environmental conditioning, as well as affective psychosocial factors precipitating consumption (Annis, 1991; de Bruijn et al., 2006). Such investigation took place within treatment-settings with an average length of participation of between 3 and 18 months (e.g. McLellan et al., 2005), though there were some exceptions of up to 3 years (de Bruijn et al, 2006) and longer (Vaillant, 1988; Brandon et al., 1990; Lloyd, 2002). Consequently, hypotheses based on findings derived from in-patient treatment-settings, were conducted at a time when the study-subjects were (negatively) at their most vulnerable (Zywiak et al., 2003) or relapse-prone (Heinz et al., 2009) or (positively) were highly motivated to engage with recovery (Nordfjærn et al., 2010).

Elsewhere, research undertaken with other addictive drugs, e.g. opiate-use (Childress et al., 1986) was then vicariously applied to alcohol-use (Weinstein et al., 1998). Not all hypotheses were empirically verified and remained theoretical ideas, but the study of alcoholism, within a broad pantheon of other addictions, appeared now common practise within the ATRF (DiClemente, 2006).

In treating relapse, the psychosocial approach adhered to two dominant theoretical positions, those of Marlatt and Gordon (1985) and Prochaska and DiClemente (1984). Marlatt and Gordon (1985) conceptualised *all* addictions as over-learned habit patterns, which could be changed through the application of self-management or self-control procedures. Yet *alcoholism,* as a culturally loaded label (Babor et al., 2010), pragmatically biased social logic to place the onus of responsibility (for initiating and stopping the addictive process) firmly at the door of an alcoholic (Clark, 2011). Unlike a bio-medical illness model (see Stage Six, above), psychosocial theories of treatment struggled to contravene this principle of natural justice, whereby a person should not be absolved from the consequences of his/her actions and that everyone should take (reasonable) responsibility for his/her own health (Berghmans et al., 2009).

As with the moral model (see Chapter 1) a person who relapsed and returned to doing what had caused the problem in the first place (i.e. relapsed) was flawed, yet responsible (Sholette, 1986), and morally culpable (Peele, 1987, 1989/1995). Therapeutically, this was unhelpful (Wilbanks, 1989), so that, over time, a model of social-learning was developed (Larimer et al., 1999) to include the Transtheoretical Model of Change, which helped chart and monitor the process of personal motivation-to-change through five stages of development (i.e. in-action / contemplation / planning / action / maintenance) (Prochaska and DiClemente, 1984). Whilst the moral burden of developing and sustaining recovery did not now rest entirely with an alcoholic, the growth of cognitive-behavioural therapies during the 1980-90's (emphasising client-choice and freewill) meant that the success (or failure) of treatment-outcome became, *ceteris paribus*, the client's responsibility (Kleiman, 2007).

Whether, ideologically, viewing alcoholism as a disease (Jellinek, 1960); syndrome (Edwards and Gross, 1976); or learned-behaviour (Marlatt and Gordon, 1985), the prevailing methods and methodology of research focused on identifying those qualities or properties of the relapse phenomenon and how these affected areas of causality, prediction and predisposition, as being useful to clinical-practice (Miller, 1991). For example, if Marlatt and Gordon (1985) were correct and relapse was a learning-experience, employed as a prelude to future success (Kleinig, 2012), then what had recovering alcoholics learned, how had they learned it and what long-lasting difference had that learning provided?

The teaching of coping-skills could occur, *a posteriori*, in the light of an historical relapse, (e.g. Marlatt and Gordon, 1985) or could be radically pro-active, in the case of cue-exposure treatment, which exposed an alcoholic to alcohol-related cues (e.g. the sight and smell of alcohol) in order to help a person practise responses in real-life situations (Monti and Rohsenow, 1999). In either case, the art of relapse-prevention was to identify and overcome the causes (triggers) of relapse, which had precipitated the urge to drink.

3.10.3 Summary

My search appeared to confirm the existence of significant conceptual differences in describing the same phenomenon; I describe these more fully below. Whilst both the biomedical and psychosocial approaches, theoretically, could serve to augment each other (Leshner, 2003), they appeared to be being presented as mutually exclusive and with little attempt at consilience (MacKillop and De Wit, 2013: 751). One postulated an essence of a fundamental nature to alcoholism (i.e. a bio-medical illness); the other labelled specific phenomena of alcoholism (e.g. triggers, loss-of-control, etc.) without always confirming that it too regarded alcoholism as a bio-medical illness, or anything other than an arbitrary concept describing such complex observed phenomena. There was a third view (Sobbell, Ellingstad and Sobbell, 2000), which eschewed all professional or mutual-help treatment and argued instead, for self-remission. Though referring to this approach, it remains outside the purlieu of this study.

However, the ATRF failed to agree what constituted or defined a relapse or how it was experienced. Either wing seemed to prefer to reify the phenomenon (Gannon, 1984), investigating it in terms of aetiology (Polcin, 1997), treatment (Castonguay and Beutler, 2006) and outcome (Donovan, et al., 2012), but rarely sought to understand the phenomenological lived-experience of what it meant to be alcoholic or to relapse. Additionally, the majority of research was undertaken within in-patent treatment-settings, with little reference to those achieving longer-term recovery. A major stumbling block, for any addiction model, was the question of freewill and choice.

3.11 Stage Eight (September/October, 2014)

3.11.1 Method

To gain an historical perspective and to understand the means and methods by which the ATRF formulated its hypotheses, between September and October, 2014, I undertook a journal run (or manual search), using selection criteria focused primarily on alcoholism (rather than addiction) and, again, covering the years 1960 to the present.

This involved searching, systematically, (by year, month and issue) the 79 journals most frequently cited within the reference sections of all research papers reviewed to date. This replaced searching selected databases using pre-set search-terms.

I made this decision because:

- I was willing to dedicate the time to this task
- This iterative process had empirical support (Bates, ibid; Greenhalgh and Peacock, ibid) as being robustly phenomenological in its approach. It would contextualise my study within the broad understanding of relapse/alcoholism, as espoused by the ATRF (Smythe and Spence, 2012)
- Though not retrieving all literature (Orlinsky et al., 1994), it provided a higher chance of comprehensively identifying and retrieving extant and relevant papers, which could be taken into account when reaching my conclusions (Petticrew and Roberts, 2006)
- It could reveal the historical train of thought which had lead the ATRF (primarily focusing on the psychosocial arm in which I worked) towards its current *zeitgeist* which tolerated relapse as inevitable. This could reveal how the ATRF reached its conclusions and potentially highlight any research problems or anomalies it encountered
- I was not sufficiently confident in the efficacy of focused data-base literature searching, as key words and phrases, used within the psychosocial field of research and AA, were idiosyncratic to those domains and were not always employed in other areas of study (e.g. “relapse” being substituted by “recurrence”). The specificity of a focused data-base search may not, therefore, have captured all relevant papers, or opinions (Bruce, 2001)
- The subjects of alcoholism and relapse are complex and interconnected phenomena, involving a multiplicity of confounding variables (Castonguay and Beutler, 2006). It seemed reasonable that in researching such broad, interconnected phenomena a wider search would be more suitable and conducive. The study’s research question was still in a matutinal stage of development and this approach could help refine it.

3.11.2 **Findings**

In total, this search yielded 300 papers, the initial findings of which can, broadly, be separated into three categories.

First, the historical train of thought which determined the ATRF's view of alcoholism and relapse was made manifest. This included the various conceptual models (moral, illness/disease, syndrome, or learned-behaviour) which had, over time, informed its treatment philosophy. These were based principally on hypothetical conjectures as how the effects of treatment would emerge during the linear lifestyle of a recovering-alcoholic; I referenced this in Chapter 1.

Secondly, within laboratory settings, the bio-medical arm focused on identifying neural circuitry which increased the vulnerability to relapse (Heinz et al., 2009) and in particular the rôle of stress, as it affected craving (Higley et al., 2011). These would be subject to improvement by the use of pharmacology (Breese et al., 2005). Consequently, this search suggested that the work of the bio-medical arm, although important within the treatment of alcoholism, was not wholly germane to this study which adopts a psychosocial approach.

Thirdly, it elucidated the methods by which ATRF psychosocial research was conducted, whereby a failure to engage with alcoholics living in recovery-oriented sobriety, restricted any comprehensive understanding of relapse. The problems which this presents can be divided into conceptual and operational difficulties which are discussed below.

On the one hand, *conceptual issues* relate to how relapse/alcoholism is defined thus determining how it is to be treated, what constitutes a successful outcome and how confounding variables may affect this, *post-partum*. *Operational difficulties* relate to how the ATRF discovers what it knows; the choice of methodology; suitable sample-sizes from which to draw conclusions; problems of attrition rates; ethical issues; and the competing claims of various treatment modalities. I will first consider conceptual difficulties and then treat operational problems second.

3.11.2.1 ***Conceptual difficulties***

3.11.2.1.1 **Problems with definition**

The psychosocial arm is replete with hypothetical constructs of recovery and relapse, where it is viewed as a return to consumption after a period of non-drinking (Edwards and Gross, 1976; The Betty Ford Institute, 2007). Some dispute the need for any definition, describing relapse as nothing more than the creation of a dominant healthcare or treatment paradigm (Moskalewicz, 2012). The bio-medical arm regards relapse as being an involuntary response caused by an illness, whereas the psychosocial arm implies that it requires a volitional intent or conscious decision. However, it is lamentable that there is, as yet, no consensual psychosocial definition as to what constitutes relapse (Kranzler and Li, 2008) and, lacking in collegiality (White, 2007), research engages in "*conceptual acrobatics*" as to whether it should form any part of treatment-outcome (Reinarman, 2005).

3.11.2.1.2 **Problems with outcome**

Working with in-patients, psychosocial research expends volumes in time and effort attempting to predict its causes (Gerwe, 2000; Gordon, et al., 2006) and thereby its prevention (Larimer et al., 1999). A divisive debate hinges on whether a recovering-alcoholic should engage with a harm-reductionist treatment programme (Single, 1996) or embrace total abstinence (AA, 1976). Historically, this centred on a debate between the efficacy of AA (which espouses abstinence and where a single drink constitutes a relapse) and professional treatment, which takes a more relaxed view (Ferri et al., 2006) allowing for slips and lapses, provided that these accord with an alcoholic's own lifestyle-goals (Marlatt and Gordon, 1985).

Due to its failure to reduce the relapse-rates of all addictions within the first year of treatment (Yates, 2012) the success of its endeavours appears to be something of a flop (Barr and O'Connor, 1985). Meanwhile, the Governmental policy change towards a recovery-based paradigm has forced the ATRF to consider recovery within a wider perspective of sustained quality-of-life. Yet the debate persists as to whether this recovery-outcome is achievable without abstinence (Donovan et al., 2012) whereas Tiffany et al., (2012) view quality-of-life as being a distal goal of personal achievement or self-validation, even though a person may still be drinking.

Whereas quality-of-life has been of ubiquitous concern to oncology and other chronic illness, judging from the submitted papers in the journal *Quality of Life Research* (1997-2017) it has been ignored by the ATRF. Not until September, 2008, with a paper on adolescent cocaine-users (Lozano et al., 2008) and again in February, 2010 (Chang et al., 2010) was alcoholism linked with such an outcome. In short, there seems to be a lack of engagement between the needs of alcoholics seeking treatment and the hegemonic needs of researchers and clinicians seeking to champion particular forms of treatment or theoretical definitions of the condition (Vrecko, 2010).

3.11.2.1.3 Problems with *post-partum* variables

Hypothetical findings suggest that relapse is a process (Brandon et al., 1990) with a causal nexus, *post-partum*, to a smorgasbord of confounding variables which affect treatment-outcome. For example:

- outcome expectancies (Connors et al., 1988)
- attentional narrowing (Gable et al., 2016)
- depression (Agosti, 2013)
- intrapersonal complications (Fernandez-Montalvo et al., 2007)
- youth and other drug-use (Nordfjærn, 2011)
- social settings (Walton et al., 1995)
- feeling healed or cured (Besançon, 1993)
- a desire to drink again (Gordon et al., 2006)
- insomnia (Brower et al., 2001)
- over-confidence (Allsop et al., 2000)
- gender differences (Sun, 2007)
- social factors and non-coping styles (Walter et al., 2006)
- treatment ineffectiveness (Allen et al., 1996)
- negative response to external stimuli (Drummond, 2000)
- craving (Subbaraman et al., 2013)
- withdrawal related stress and anxiety (Becker 2008)
- poor quality-of-life (Peters et al., 2003)
- temptation (Witkiewitz, 2013)
- time of day, place and company (O'Donnell, 1984)

- and substance availability (Tate et al., 2006), etc..

There is, perhaps, some intuitive appeal which suggests stress (physical or psychological) precipitates relapse (Brady and Sonne, 1999). As a causal factor, it is supported by empirical evidence from both the biomedical (Sinha, 2012) and psychosocial divide of the ATRF (Silvers, 1993; Khantzian, 2011). Walter et al., (2006) argue, however, that social factors predict relapse and not stress coping-styles. But stress is only one potential relapse-trigger and whether it is exacerbated by internal factors which, negatively, affect mood levels (Trucco et al., 2007) or results from external events, which are falsely assessed as being painful and requiring of the mellifluent affects of alcohol (Hore, 1971), is not apparent. The conceptualisations of relapse, though extensive, focus predominantly on an alcoholic, *post-partum*, via discrete triggers, rather than taking an *a priori*, holistic exploration of the lived-experience of what it means for him/her to be alcoholic, as is the case with other chronic illnesses (Arria and McLellan, 2012).

3.11.2.2 ***Operational difficulties***

3.11.2.2.1 **Problems with methods/methodologies**

The ATRF garners insight into these multifarious hypotheses through studies on active alcoholics, ubiquitously within treatment, using observational or prospective cohort studies and rarely benefiting from longitudinal analysis (*pace* Vaillant, 2003). As it contemplates sustained-recovery it becomes increasingly speculative. Instead, it relies on traditional methodologies to analyse the efficacy of its usual treatment methods (Truan, 1993) rarely questioning (*pace* Margolis, 1993) the over-reliance on the researcher's expertise which, in the area of sustained-recovery, is of minimal value (Emrick and Hansen, 1983).

Historically, it may acknowledge a lack of academic rigour in its research (Kelly et al., 2011), occasioned by: the complexity of the subject under review; operational difficulties; the lack of consistent findings, potentially reflecting heterogeneous subgroups according to problem severity; duration of alcohol ingestion; and personality and concomitant negative consequences (Miller, 1991).

A further explanation for this inconsistency, apparent from this manualised literature search, was that studies utilised different study populations, sample-sizes, follow-up periods, modality structures and assessment measures, not always optimally tailored for clinical application (Zywiak et al., 2003), which could influence results (Fiorentine and Hillhouse, 2003).

Operational problems affecting hypothesis formulation, centred on the key areas of:

- sample size and gaining access to participants
- chronicity/attrition rates
- ethical concerns and the absence of randomised control trials (RCT's)
- the variety of treatment modalities with differing outcomes
- confounding variables
- researcher bias
- and, doubts concerning the reliability study participants' self-report.

All these elements could adversely affect the veracity of data which, subsequently, undermined the rigour of research findings. These seven methodological problems are now reviewed in turn.

1) Sample sizes: gaining access to participants

Study participants were secured from in- and out-patients attending treatment-centres. This was legitimate for reasons of time and cost (Roehrich and Goldman, 1993), but involved centres utilising different treatment modalities, with follow-up at intervals of 3-6 months and seldom more than 12-15 months, except with those occasional studies involving RCT's (Kelly et al., 2006; 2011). A significant drawback was that clinical research-settings imposed artificial schedules and devised artificial assessment-tasks for participants to perform (Tuunanen et al., 2013) and, being dissimilar from real-life situations, were likely to yield results of equal artificiality and bias (Ludwig and Wikler, 1974).

Secondly, by using in-patients, most studies involved cohorts who were, statistically, studied *at their most relapse-prone* and, even at 6 months, were 70-80% more liable to recidivism (Babor and Del Boca, 2003). Bates, et al., (2002) argued that because few in-patient treatment programmes lasted beyond 28 days, patients remained affected

by the neurotoxicity of their long-term exposure to alcohol, resulting in reduced cognitive functioning. Consequently, they were unable to engage, meaningfully, with psychotherapeutic interventions (or researchers' questioning). This was evident where alcoholics were expected to generalise, what they learned within treatment, to real-life situations, a task that required the very abstraction and conceptual abilities most likely to be impaired by prolonged heavy alcohol-use (McCrady and Smith, 1986).

The methodological limitation of using in-patient participants resulted in small sample-sizes (Higley et al., 2011) which, as findings were intended to be generalised, failed to yield representative pictures of a wider population with substance-addiction. Many studies involved participants from the lower socio-economic strata of society, whose general profile reflected a direct relationship between social-deprivation and specific personality types or what Zinberg (1967) termed *oblivion seekers*. A second group, from the middle and upper socio-economic strata, termed *experience seekers,* would seldom label themselves as "alcoholic" and rarely formed part of research studies. Yet findings were assumed, or implied, to apply broadcast to the entire field of addiction.

Small sample-sizes may not provide proof of an argument, but were regularly used to assist in formulating hypotheses, which were treated as representing empirical fact. Research was even conducted with participants who were abstinent for as a little as 4 days (Trucco, et al., 2007), and, potentially, still undergoing medical detoxification. Conversely, there was minimal research with treated alcoholics/addicts, where recovery could be termed "sustained" (up to 5 years in remission) and "stable" at 5+ years (Hibbert and Best, 2011) confirmed by long-term (60 years) follow-up data on alcohol-abuse (rather than dependence) which suggested that, at this level, annual hazard rates of relapse dropped to 2.6% (Vaillant, 2003). Problems of sample representativeness and generalisablity of sample-sizes was a limitation noted within most studies (Best et al., 2008).

2) Chronicity/attrition rates

Longitudinal studies experienced higher than average attrition rates due to withdrawal, relapse and oftentimes mortality (Barr and O'Connor, 1985), giving credence to the chronic-relapsing nature of the condition (Levy, 2008). Additionally, many newly sober alcoholics, recruited for (US) studies, which Lillibridge et al., (2002)

note constitutes the bulk of ATRF research, were drawn from halfway houses. These alcoholics, frequently, geographically relocated as they attempted to recover from their addictions (Dunlop and Tracy, 2013). Therefore, large numbers of people needed to be followed-up for long periods, before sufficient cases accrued to give statistically meaningful results; this was rarely possible (McKay and Hiller-Sturmhöfel, 2011).

The same problems occurred with in-patient, observational studies, where patients were not psychologically fit to engage with research due to cognitive dysfunction (Bates et al., 2002), as well as cohort studies within AA, where drop-out did not follow any predictive pattern (Huebner and Kantor, 2011). This created something of a cyclical dialectic which conditioned the methodological choice as, given the thesis that alcoholism is incurable (Boschloo et al., 2012) it, logically, follows that if no single treatment for alcoholism is curative, then all must be of equal validity (Ferri, et al., 2006). Yet the purpose and goal of researchers, espousing particular treatment modalities, was often to demonstrate that one, rather than another, was to be viewed as optimal in successful addiction treatment (Timulak, 2005).

3) Ethical Concerns/Absence of RCT's

AA is seldom studied via the gold standard of an RCT (Kelly and Greene, 2014). Treatment protocols (i.e. 12-Step meetings) would not be under researcher control and there exists a wide variation in size, content, organisation and participant composition of AA meetings (Hoffmann, 2003). Furthermore, there would be strong ethical concerns about researchers requiring (if not coercing) individuals to avoid free community resources (e.g. AA), which could impair recovery (Barber et al., 1995). The same would apply to RCT studies into stress and its effect on relapse with alcoholics attempting abstinence; such studies are not ethically tenable (Thomas, et al., 2011). Consequently, RCT's, as a means of study, were not always feasible (Kelly and Greene, 2014).

Therefore, the *modus operandi* of the ATRF had been to generate a hypothesis, redolent with theoretical bias (Polcin, 1997), build a model and then subject it to empirical testing (Moos, 1994; Takeda et al., 2013). Through a range of quantitative/qualitative methodologies, or predominantly an admixture of both, (observational/or cross sectional; prospective/longitudinal; or retrospective studies)

many employing surveys (Thoreson et al., 1986) with structured or semi-structured interviews (McIntosh and McKeganey, 2000), studies focused on three phases of the condition; prevention, treatment and recovery (Harris et al., 2011).

In many cases (e.g. Jellinek, 1960; Edwards and Gross, 1976; Marlatt and Gordon, 1985), whilst these hypotheses were based on clinical observation, the ATRF linked them, I suggest, to the notion of *petitio principii*, whereby the truth of the proposition (as yet to be demonstrated) was generally accepted as being valid by the very premise of that proposition and because it, generally, seemed more likely to conform to the observable aggregate of the phenomena under discussion or was in line with the current clinical *zeitgeist*.

4) Differing treatment modalities and outcomes

Given the lack of consensual agreement with its definitions of terms, valid comparison with other like-for-like studies was difficult (Barr and O'Connor, 1985; Anton, 1999), with differing treatment modalities having divergent epistemological and ontological positions regarding the nature of addiction and its treatment/outcome expectancies (Rahill et al., 2009). The assumed goal was to treat addictions, simultaneously, with their presenting co-morbidities, rather than, initially, treating the addiction in terms of resisting urges/craving (Scott et al., 2005). This was followed by addressing other potential underlying issues, given that, for example, co-occurring depression and anxiety are believed to be substance-induced (Stalcup et al., 2006). This integrated or *aegis* approach is the hallmark of most treatment settings, even though relatively little is known about the efficacy of transdiagnostic or integrated treatments compared with single-disorder treatments (Bergmark, 2008). Consequently, this stimulates my research to focus on people who experience alcoholism as their sole presenting problem.

Beliefs about negative-affect, as a predictor of relapse, were reported retrospectively, with little evidence for any systematic correlation between affect and alcohol resumption (Piasecki, 2006). This may be fashioned either by experiences during previous failed attempts to stop or by experiences with affect-laden withdrawal symptoms. Potentially, interoceptive cues (which signal impending negative-affect)

may come to serve as discriminative stimuli capable of pre-consciously prompting drinking (Fergus and Shiffman, 2009).

It was, tacitly, assumed that all forms of addiction followed roughly the same observable, homogenous cycle, (i.e. use/abuse/dependence/negative-consequence/reduced inhibitory-control/recovery/relapse), allowing for differences in severity-of-use and negative consequences (Vaillant, 1988). Significantly, with all addictions frequently being studied *en masse,* research findings became increasingly interchangeable (McKeganey, 2014). Concomitantly, it became apparent that researchers of different professional and scientific cultures, ideologies, ethnic and national backgrounds and working in different areas of the addiction debate, may not have been evaluating the same questions in terms of comparable measures (Peele, 1987).

This included, first, the over-riding aims and outcome-objectives of treatment: either an overall symptomatic amelioration (Miller, 1991); or a client-perceived enhancement of quality-of-life (Tiffany et al., 2012), or total abstinence (Donovan et al, 2012). Secondly, there was an haphazard usage of terms to describe the *active* condition (e.g. addiction, substance-abuse, dependence, psychiatric disorder, etc.,) or its *inactive* state (e.g. abstinence, recovery, recovered, ex-addict, remitted) (McIntosh and McKeganey, 2000). Thirdly, what constituted a *lapse* or *slip*, as opposed to a full *relapse* (Rahill et al., 2009), when determined by the units of alcohol consumed, was not clarified (Donovan et al, 2012). A *lapse/slip* was, permissively, dismissed as being "*relatively unimportant*" for ultimate therapeutic success (Littleton, 2000: 88), whereas the aim of the RPM was to prevent a lapse becoming a relapse (Marlatt and Gordon, 1985). There were also significant variations as to what constituted a single unit of alcohol (Turner, 1990).

Witkiewitz (2005), who champions a harm-reductionist approach, argues that initial lapses, followed by a volitional return to abstinence, is the rule not the exception and that most treatment studies, *of alcohol disorders*, do not find an automatic return to a full-blown relapse. Saunders et al., (1993) citing a study by Hall and Havassy (1986) indicated that alcoholics with a robust resolution for change and who indicated that they chose abstinence, were slower to return to drinking. Equally, abstinence did not always mean not-drinking, especially for those not attending treatment-centres

(Sobell, Sobell and Leo, 2000) or self-remitting (Sobell, Ellingstad and Sobell, 2000). As an outcome-measure, relapse was variously interpreted to mean: less volume-of-drinking over a set period; fewer drinking days with less attendant problems; and even extended to refer to psychosocial health improvements rather than drinking patterns (Schneider et al., 1995; Trucco et al., 2007). Such measures of outcome, however, could only provide aggregate measures of overall treatment effectiveness.

Somewhat confusingly, therefore, patients could be viewed as being in remission (i.e. abstinent) whilst still engaging in controlled-drinking, consuming alcohol regularly, even excessively, yet not becoming intoxicated or experiencing previous levels of alcohol-related social, legal or employment problems. This pattern could appear the longer patients were separated from abstinence settings and cultures (Peele, 1987) or achieved new identities other than those of "alcoholic" or "patient" (Schneider, et al., 1995).

Overall the literature reviewed suggested that better, long-term outcomes were predicted by certain characteristics: e.g. female gender; marital status; lower levels of severity; late age at onset; abstinence goals; employment status; socio-economic background; treatment characteristics and extra treatment characteristics, such as membership of AA (Mertens at al., 2012).

Alternative studies examined spontaneous or self-change remission (Peele, 1987; Sobell, Ellingstad and Sobell, 2000), where the assessment of change was restricted to the period immediately prior to its initiation. Subsequently, predicting relapse from a "snapshot" of withdrawal (taken early on in the quit-attempt) made sense under a narrow set of assumptions, viz., that withdrawal unfurls in a stereotyped fashion across all alcoholics and that its peak (i.e. the period of maximal relapse risk) occurs early in the cessation attempt (Piasecki, 2006). However, when analysed in the aggregate, withdrawal symptoms may increase sharply on cessation and then decrease to baseline within 3-4 weeks, but this mean-pattern masked considerable inter and intra-individual variability. Relapse symptoms may be more variable after detoxification than before, suggesting that alcohol may buffer, or constrain, aversive symptoms which are "unleashed" by cessation (Piasecki, 2006).

5) Static and Dynamic Confounding Variables (pre- and post-treatment)

Variables determining the acquisition of alcoholism, like those affecting treatment effectiveness, may not be static but fluctuate in salience during the lifespan of an alcoholic (Castonguay and Beutler, 2006). (A list of 29 confounding variables, considered by papers within this literature search, is provided in Appendix 8). I have detailed (above) *post partum* variables which are hypothesised to affect relapse. The difficulty is determining which of these, singly or in aggregate, continues to be critical during sustained-recovery or whether, as time passes, additional variables, potentiating relapse, assume importance. Conversely, what is not understood, are those dispositional qualities or psychological and emotional characteristics needed to countervail relapse-precipitants and which secure lasting abstinence-based recovery.

Gerwe (2000) argues that, post-treatment, life-stressors produce anxiety that is readily alleviated by resumed drinking, so that, with repeated relapse, a stigma of failure emerges which maintains negative social perceptions spilling over towards abstinent-alcoholics throughout their recovery (Kairouz and Dubé, 2000). But for those in sustained-recovery (1-5 years), the greatest factors in predicting relapse are hypothesised as being: social pressure; life circumstances; coping-resources; and attitude (Zywiak, et al., 2003).

Regardless of any theoretical orientation, most treatment models valued, for the purposes of relapse attenuation, the development of social-skills affecting the self-concept and self-esteem (Trucco et al., 2007). This was seen, psychotherapeutically, as part of a volitional subsystem of motivation and self-determination to change (Gorski, 1986). *Post-partum* these included, social support, family involvement (Sobell, Sobell and Leo, 2000), or attending community mutual-help-groups, e.g. AA and treatment aftercare, following a proto-typical 28 day in-patient treatment programme (Gerwe, 2000; Stalcup et al., 2006).

6) *Research bias*

Implicitly, confounding variables point to the diversity of experiencing and highlight the self-evidentiary fact that people are unique so that, when assembled into groups, such groupings are heterogeneous (Raistrick, 1989). Yet, at initial, pre-test assessments the application of baseline, standardised preset questionnaires is

regarded as an essential part of the apparatus for any research, aiming for both homogeneity and the elimination of bias. Where these are not considered suitable, bespoke assessments were created (e.g. Billings and Moos, 1983; Levy, 2008). Yet, without a clear definition of terms (Rahill et al., 2009), it is hard to tell what is being measured (Anton, 1999) and this lack of consensus does not promote the sustained momentum for the adoption of a standard battery of assessments (Tiffany et al., 2012).

It is believed that assessment-tools provide good indices of reliability, being moderately correlated with each other. This offers the means by which some statistical control of potentially confounding variables can be achieved (Garfield, et al., 2014) though, potentially, yielding more conservative estimates (Kelly et al., 2012). Whereas variables may, prospectively, help distinguish who might be at risk of becoming alcoholic, they cannot predict who, amongst the dependent, will be unable to control their drinking and so relapse (Abrams et al., 1986).

Collectively, the literature searched used over 60 different assessment-tools for pre- and post-treatment outcomes. Where participants were male, Caucasian, well-educated, employed and treatment-seeking, there were mixed views on the construct validity of assessment protocols (convergent and discriminant) resulting from their cultural and class bias (Pittman, 1988). Some tools, especially those affecting self-efficacy and expectancy about future drinking, are known to be skewed towards positive expectancy, which significantly underplayed the volume of alcohol consumed (Tuunanen et al., 2013), thereby increasing the likelihood of result bias (Garfield et al., 2014).

The regular application of baseline questionnaires, sought to minimise confounding variables for the benefit of a study and prove, by empirical means, how relapse could occur, primarily in terms of cognitive or other internal state changes, rather than how a person operated within his/her environment (Walton et al., 1995). These differing perspectives created differing methodological approaches. The social-cognitive/behavioural perspective (Marlatt and Gordon, 1985) relies on an alcoholic to identify, by means of a Likert-style scale, the various relevant confounding variables (i.e. internal state changes) without measuring any external environmental contexts, which are acknowledged only in as much as they affect the internal states.

This focuses on attributional processes and a participant may obscure/miss controlling variables (Seneviratne and Saunders, 2000), compounded by coder-bias (Nordfjærn et al., 2010), which are either outside an individual's awareness, or develop over long periods. Conversely, a purely behavioural perspective objectively seeks to characterise the environmental context surrounding behaviour change, as well as assessing an alcoholic's own causal attributions, so that there are levels of convergence and divergence between both levels of analysis, each having validity (Kelly et al., 2009).

7) Problems with self report

In assessment, researchers are forced to rely largely on self-reported data, usually without independent, collateral confirmation which limits the study design and validity (Donovan et al., 2012). This is a contentious issue. It is argued that self-report is generally reliable (Thoreson et al., 1986) provided that a participant is alcohol-free (Schneider et al., 1995) but it could be subject to bias (Cheney et al., 2009) or wilful or accidental distortion (Donovan et al., 2012), especially where there has been a return to controlled-drinking (Vaillant, 2003). It is assumed that all participants matched DSM criteria for dependence, but this was not always the case (e.g. Fiorentine and Hillhouse, 2003).

The question of the validity of self-report is discussed at length in Chapter 13 (Limitations). At this stage of my research, it was sufficient to recognise that, first, the narrative of an alcoholic was not, universally, regarded as being reliable, which legitimised the need for expert researcher interpretation and the creation of standardised assessment-tools (Sharpe, 2001). Secondly, the ATRF's view of self-report was, predominantly, influenced by its research with neophyte recovering-alcoholics and rarely with those in sustained-recovery (Laudet et al., 2014); but, thirdly and pragmatically, though the variety of expressions of experience were diverse and militated against the attempts to introduce homogeneity within a study's data, self-report invariably served as a primary source of information for clinician and researcher (Del Boca and Noll, 2000).

3.11.2.2.2 Summary

The psychosocial approach to alcoholism struggles to create a consensual definition of relapse, which materially affects any measurement of a successful outcome arising

from treatment. *Post-partum*, additional confounding variables are believed to affect sustained-recovery, quite apart from those which influence the acquisition of alcoholism. Attention is rarely paid to what it means for a person to be alcoholic or one attempting to live a life of recovery (however they choose to define this).

Current methodological approaches restrict the discovery of aspects of recovery by:

- the continued study of small, heterogeneous study populations whilst still undergoing treatment and short follow-up periods, *post-partum*
- therapeutic modalities desiring different outcomes
- and assessment measures whose artifice seeks to homogenise study participants and exert some conformity on research findings by eliminating researcher/participant-bias.

There is rarely any insight gained via prospective research yet, despite these limitations, findings are vicariously applied as being legitimately transferrable to all study populations. Furthermore, a fundamental problem exists regarding the ambivalence surrounding the trustworthiness of an alcoholic's self-report, which is the primary source of information and subjective experience of what alcoholism/relapse entails.

3.12 Stage Nine (January, 2017)

3.12.1 Method

In January, 2017 a second and final manual search was made of all 79 research journals, originally viewed in September/October, 2014 and covering the period from that date to the present. Its purpose was to discover if any comparable research had been made into the phenomenon of relapse in the intervening period since my study had begun (there had not) and note any changes in the ATRF's approach to addiction. 84 further papers were found and 82 formally reviewed within this search and were critiqued systematically.

3.12.2 **Findings**

Whereas there were various qualitative and phenomenological studies addressing alcoholism/recovery, nothing was found comparable with my research question. I discerned a changing trend within addiction treatment, particularly regarding attitudes towards alcoholism as being acceptably defined as a *disease* or *chronic illness* (Miller, 2015). In turn, this had precipitated, within the last ten years, a substantial focus on the rôle of *quality-of-life* (e.g. Subbaraman and Witbrodt, 2014) as part of a new recovery-based approach to treatment (e.g. Leukefeld, 2015).

Whilst some historic definitions of alcoholism and other addictions (e.g. ASAM 2011), were gaining consensual currency within the ATRF, e.g. that it was an illness; that recovery should be defined, (The Betty Ford Clinic, 2007); or that treatment needed to be viewed as a long-term process, there still remained a confusing, multiplicity of definitions as to what could legitimately be described as a relapse (Maisto et al., 2016); nor did there appear to be any attempt to assimilate relapse-experiences into the recovery process.

This search further highlighted the understanding that alcoholism was a heterogeneous combination of neurological changes and lived-experiences and that its study, as a chronic illness, should be better co-ordinated but under the hegemony of the bio-medical arm of the ATRF (Litten et al., 2015); that debate is still alive. But, there was an embryonic suggestion that experiential and phenomenological studies of alcoholics (in longer-term recovery) were becoming increasingly desirable (Subbaraman and Witbrodt, 2014; Caselli and Spada, 2015) and that understanding lived-experiences was essential if a recovery-based paradigm was going to be pursued (Kidd et al., 2015).

3.12.3 **Summary**

Despite changes to its treatment paradigm and the consideration of quality-of-life as being an essential outcome-goal, the distal or proximal rôle which relapse/abstinence plays within that mix is still undecided. There is a gradual move towards considering lived-experience as informing what form sustained-recovery might take.

3.13 Stage Ten

3.13.1 Grey Research literature

This area yielded disappointing results. Beyond my own MA research (Gubi and Marsden-Hughes, 2013) there was only one paper within the British Association of Counsellors and Psychotherapist (BACP) website which addressed addiction and linked it to Bowlbian attachment theory (Bowlby, 1997); this was not relevant. Governmental websites similarly were devoid of germane references. Of the seven autobiographical accounts of alcoholism and addiction I read (Cormier, [2013]; Denzin, [1987]; De Quincey [1823/1994]; Gascoigne [2006]; Greaves [2004]; Moyers [2006]; Wright, [2007]), relapse was couched in terms of failed attempts to gain sobriety (Miller et al., 1996) which, once achieved, the struggle was ennobled by sustained, long-term sobriety. *In fine*, once sobriety was achieved relapse, as a phenomenological entity, disappeared.

3.14 Chapter Summary

There is no consilience, between either wings of the ATRF, regarding the definitive treatment of alcoholism nor is there any collegial definition of relapse (Maisto et al., 2016). For chronically severe drinkers, abstinence may be the only logical outcome-goal, but the biomedical arm has now abandoned its attempts to reinforce abstinence by the use of pharmacological agents (Knopf, 2015) and the psychosocial arm maintains its view that recovery-outcomes are a matter of personal choice (Tiffany et al., 2012). Relapse may prove fatal, so that if it forms an ubiquitous threat to recovery, then managing an abstinent lifestyle is not mere whimsy.

Understandably, ATRF research focuses on alcoholics undergoing treatment, whereas studies involving people in longer-term recovery (who may avoid relapse) are not easily accessed and not within its current remit. With the move to a recovery-based model of treatment and away from acute, short-term interventions, the ATRF avers that*, "without patient voices directly represented in research, (*Meisel and Karlawish, 2011*) we may miss a relationship between the biological and social narratives of*

addiction that would better unite the efforts of all those who seek to care for those suffering the throes of substance abuse" (Hammer et al., 2012: 732).

Chapter 4 examines how the ATRF has addressed this question through its deployment of various research methodologies and, in particular, examines its phenomenological foray into understanding the lived-experience of recovery and relapse after active-alcoholism.

4.0 Chapter Four: The Literature Review

In this chapter I review the ATRF's attitudes towards lived-experience by evaluating 77 papers, retrieved from previous literature searches, grouped by methodology and examined in a systematic fashion. No papers considered the experiences of relapse amongst longer-term recovering AA affiliates. Two papers, identified as being tangentially relevant, explored the rôle of metaphor in illuminating descriptions of lived-experience. Reasons for deselecting papers are given on a case-by-case basis.

4.1 Theory pertaining to literature reviews as applied to psychotherapy

Dallos and Vetere (2005) posit that literature reviews analyse and establish the validity of the literature-search findings; contextualise the necessity for the current research question in the light of previous enquiries and clinical thinking; so that the need for a new line of enquiry (if it is to develop and advance understanding and practice) is seen to arise, naturally, from the review itself. This is supported by Creswell (2007) and is what Shulman (1999: 161) terms "*generativity*" or the ability to build upon prior scholarship. But there appears to be no one way to effect a literature review (Smythe and Spence, 2012).

Where suggestions are made specific to psychotherapy, (e.g. Sanders and Liptrot, 1994; McLeod 2001, 2003; Dallos and Vetere, 2005; Timulak, 2005), as with their social-science counterparts (e.g. Hart, 1998), reviews tend to focus on the critical analysis of treatment-effectiveness and outcomes (Cooper, 1988; Elliott and James, 1989; Roth and Fonagy, 2005). A plethora of theoretical descriptions detailing the purpose of literature reviews exist, but finding an exemplar of a definitive analytical format is difficult (Boote and Beile, 2005) and vague (Bruce, 2001).

To achieve analytical rigour, Petticrew and Roberts (2006) counsel against the temptation to use off-the-shelf analytical tools and Timulak (2005: 64) describes the reviewing process as "*a creative theoretical evaluation*" of findings and methodologies. McLeod (2001) argues that this analytical process is generic to the whole study and not only confined to a formal review of literature.

As Dallos and Vetere (2005) aver, the inevitable starting point of psychotherapeutic research is, most likely, the researcher's clinical experience so that, for example, in questioning why people relapse McLeod (2003: 9) suggests that the literature review remains mindful of this, so as to "*maintain a live dialectic relationship with [clinical] practice*." Smythe and Spence (2012) describe this as maintaining congruence between the review and the study's particular research methodology.

My review focuses on:

- how the ATRF uses the raw data of lived-experience within in its various methodological approaches to understanding alcohol/relapse
- what value it attaches to lived-experience within that process.

My belief in the centrality of lived-experience (in understanding relapse) needed to be reflected in my research question (Randolph, 2009) and this review offered me the timely opportunity to refine this (Petticrew and Roberts, 2006).

To create an analytical structure to attend to the question of my review's reliability and validity and to approach my analysis of differing research studies, systematically, I have combined the theories of Petticrew and Roberts (2006), in refining the research question; Boote and Beile, (2005), in identifying the ATRF's main methodologies and research techniques; and Cooper (1984), in avoiding a detached or neutral perspective, revealing my pre-existing biases within the analysis.

Consequently, the chapter is divided into five sections:

- Refining the research question
- Preparing the inclusion/exclusion criteria
- Defining the parameters of the literature review
- Assessing the study quality
- Drawing conclusions.

When reviewing each paper attention was paid to the following, as suggested by Boote and Beile (2005):

- A clear statement of the study's aims

- An appropriate corresponding methodology
- The sampling methods and composition of the participants or sources of data
- Ethical considerations
- The origin of the paper (and hence its cultural milieu)
- The quality of its description of lived-experience.

(An extract of the individual analysis of all 77 papers is provided in Appendix 7.)

4.2 Refining the question

Petticrew and Roberts (2006) suggest that reviews help refine the research question.

My clinical starting point was mirrored in the eponymously titled paper by Moos (1994):

"*Why do some people recover from alcohol dependence, whereas others continue to drink and become worse over time*?"

In particular, I sought to understand the rôle (positive or negative) which relapse played within this process. My response to the literature review posed certain questions:

First, if at the point of treatment it is reasonable to treat all addictions as being one-and-the-same, why at the point of treatment-outcome does the ATRF address them differently? Why, as a treatment-goal, was abstinence mandated for all other addictions, but not alcoholism?

Secondly, if alcoholism is a chronic illness why was it pre-supposed that having this illness included some intentionality on the part of an alcoholic? If a sufferer from diabetes is not held responsible for his/her condition, why does some residual notion of blame attach to a sufferer of alcoholism? I suggest that a chronic illness is something that a person *has* not something that s/he *does*.

Thirdly, why did the ATRF appear reluctant to engage with AA, particularly those affiliates who were achieving sustained-recovery; were there no lessons to be learned? Though clinical attitudes indicate that ATRF research is considered more "professional"

than the “amateur” work of AA (Le et al., 1995), was it to be assumed that the mechanisms of change operating within the two were so different (Miller, 1998)? AA emerged because professional approaches had failed to find solutions to the problems of alcoholism (Khantzian, 1985) and, notwithstanding any differences, the 12-Step programme of AA is incorporated within some ATRF treatments (Mäkelä, 1993), although not all professionals encourage AA attendance (Lopez-Gaston et al., 2010) and some have negative attitudes towards addicts of any kind (van Boekel et al., 2013).

My second manual journal-search had indicated that, unlike other addictions, abstinence (for alcoholism *alone*) was no longer the end-game of bio-medical interests, with pharmacological attenuation appearing impossible (Knopf, 2015). In view of the *zeitgeist* of a recovery paradigm (Miller, 2015), it also showed that the psychosocial wing acknowledged that it required a more comprehensive understanding of the processes and recovery-tools utilised by both non-abstinent and abstinent people (Subbaraman and Witbrodt, 2014).

Given that little was known about the “*perceptions of recovery, per se*” (Laudet, 2007: 244), my study could assist in understanding the recovery-styles and processes of some *abstinent* alcoholics if I reframed my research question to elicit their perceptions by asking, in simple terms:

“How do recovering-alcoholics, attending Alcoholics Anonymous, view the phenomenon of relapse?”

Implicit in this question were two assumptions. First, that participants (being AA affiliates) adhered to the principle of abstinence, enjoyed longer-term recovery (1-5 years) and had not relapsed for at least two years (i.e. my participant criteria, see below). Secondly, that their perceptions of relapse, potentially, strengthened their abstinence-based recovery. This might also redress societal perceptions of recovery which viewed it as meaning nothing more than that a person was currently trying to stop drinking (Hart, 2004).

Taking a more nuanced approach than Moos (ibid), I questioned why alcoholics, embarking on their pathway to recovery (i.e. after making the achievement and maintenance of a sustained-abstinence-based lifestyle a volitional goal), paradoxically, violated this avowed intent, by returning to atavistic behaviour and cognition (Takeda

et al., 2013). *Behaviour* meaning that they consumed alcohol and *cognition* referring to their belief (perhaps) that they possessed the self-efficacy to drink and a positive expectancy that consumption would be salutogenic (Marlatt and Gordon, 1985).

Additionally, while papers within this review studied the lived-experiences of change and growth such as: the formulation of a new recovery–identity to enhance quality-of-life (Hibbert and Best, 2011); or the importance of abstinence (Vaillant, 1988); or making meaning from relapse (Dunlop and Tracy, 2013) the aims and findings of this research were, presented in terms of factors which influenced, predicted or were indicative of relapse as they affected sustained (professional) treatment-outcomes. Change of identity, sense-making and alterations in behaviour and cognition are, in PCA terms, aspects of the transformation of self or self-construct which, when told through the organisational structure of a life-story, are considered in terms of how genuinely "actualising" such changes might or might not be for an individual.

In sum, my study was seeking to understand how and whether, through the perspective of an individual's presentation of his/her life-story, the hypothetical conclusions of the ATRF were relevant within their recovery lifestyle and, if so, what differences might exist between participants? How did they view their subjective transformation (an identifiable, though ill-defined theme within ATRF literature) from one way-of-being to another? What did this mean to them? Did they possess intrinsically personal, definable ways of establishing criteria for success or failure which were not to be found within mainstream treatment interventions? And, what impact did a relapse-experience have on their process of recovery?

4.3 Preparing the inclusion/exclusion criteria

My research question informed the inclusion/exclusion criteria for my study. Whereas the ATRF makes no particular distinction between the research and treatment of addictions of which alcoholism is a part (DiClemente, 2006), my study focused, exclusively, on perceptions of relapse within alcoholism. As such, my inclusion and exclusion criteria, outlined within the "Request for Participation Letter" (see Appendix 2) aimed to eliminate confounding-variables which could obscure this purpose and

sought participants regularly affiliated with AA (Ogborne, 1993), described within AA literature but not, necessarily, in mainstream ATRF research:

"You are eligible to join if you would describe yourself as matching the following:

1) *You are in recovery from alcoholism as your primary and sole drug of choice.*
2) *You regard yourself and label yourself as having been addicted to alcohol and for whom alcohol consumption became habitual and problematic.*
3) *You are an active member of Alcoholics Anonymous (AA) and follow the 12-Step Programme as laid out by AA.*
4) *AA is your main support network in sustaining your recovery, though you may engage with other support networks (e.g. Church, Synagogue, Temple, other religious or social community groups).*
5) *You have relapsed at some point in your recovery (this may be one occasion or several times).*
6) *You would describe yourself as being in recovery.*
7) *You have been sober for a period of at least one year since your last relapse.*
8) *You may, or may not have sought professional therapeutic help to change your drinking habits (i.e. personal therapy, outpatient or in-patient attendance at a treatment centre, NHS Drug and Alcohol Service, etc.).*

You are not eligible to join if you fulfil the following:

1) *Persons for whom alcohol has not been their primary and sole drug of choice.*
2) *Persons who are in active addiction.*
3) *Persons who are under 18 years of age.*
4) *Persons who have relapsed within the last 24 months."*

As the literature search papers treat alcoholism in common with all other addictions, rigidly applying these criteria within this review would have meant, effectively, dismissing all papers. These participant criteria described what was being defined by the term "alcoholic", for the purposes of this study, yet the specificity of my criteria also indicated that my area of research was otherwise unexplored. Even where alcoholism is stated as the primary addiction, ATRF research-participants frequently exhibited other comorbid drug-use (e.g. Wasmuth et al., 2014), or psychiatric problems believed to trigger relapse (Nordfjærn et al., 2010).

Not only was *abstinence* rarely "*entire*" (AA, 1976: xxviii), but the term "alcoholic" diagnostically defined someone along a broad continuum of alcohol-use (DSM 5). When I refer to a person as being *alcoholic*, it is not in a diagnostic manner, but phenomenologically, i.e., as one who self-labels and whose self-construct identifies him/herself as using alcohol in a manner which s/he perceives as creating unacceptable problems (of any kind), to the extent that these need to be addressed by choosing abstinence and for which an affiliation with AA is beneficial. I define *abstinence* in line with the golden rule of AA (1976), meaning the ingestion of a single alcoholic beverage. This does not extend to the taking of clinically prescribed medicines, or legal substances (e.g. nicotine or caffeine) which, admittedly, possess addictive properties (Piasecki, 2006). Nor am I suggesting that AA/abstinence is the only alternative for someone who is alcoholic.

4.4 Defining the parameters of the literature review

Revisiting prior literature searches, I selected papers whose title/abstract included the words: *narratives*, *stories*, *accounts*, *(lived)-experience(s), abstinence*, *AA*, *autobiography*, *meaning*, *recovery*, *pathways*, *views*, *voice(s), phenomenological*, *follow-up*, *insider*, *vignette*, or *client's perspective*. Seventy seven papers in total were collated and re-read.

Following Boote and Beile (2005), the guiding principle was deciding whether a methodology was sympathetic to eliciting a rich and subjective description of lived-experience, as described by its participants (Randolph, 2009) or whether experience was interpreted/reified into fixed, empirical constructs, in order to prove *a priori* hypotheses or create an overarching theory of what it meant to relapse (Gannon, 1984). The origin of the data-source would be significant, whether this reflected lived-experience re-presented from first-hand recovery-narratives or was interpreted from questionnaires or second-hand surveys.

My review suggested that *lived-experience* appears as an abstract construct meaning little more than how researchers analyse and interpret data gained from structured and semi-structured interviews and the coding of narrative transcripts to reduce the data to a set of themes. Previous papers recognised that little is known about

alcoholism's aetiology (Brewer, 2006); how long a person should engage with any form of treatment (Elsheikh, 2008); the practicalities of quotidian-living in recovery (Best and Lubman, 2012), or the experiences of relapse (DeLucia et al., 2015).

Gaining insight into this specific area of human knowledge was predetermined by a battery of analytical tools, aimed at reducing *experience* to a set of reified empirical variables. Deductive studies drew upon tested *a priori* concepts already assumed in existing theories (e.g. Seneviratne and Saunders, 2000), whereas other (inductive) studies viewed this as restrictive, preventing new insights into what it meant to live in recovery (e.g. Wasmuth, et al., 2014).

Understanding/interpreting lived-experience served to highlight potential triggers or variables (Hammer et al., 2012) predictive of relapse (Connors et al., 1988) or adversely affecting recovery and, in the tried and trusted spirit of cognitive and behavioural therapies (Koski-Jännes and Turner, 1999), helped devise coping-strategies which could attenuate disaster (Neale et al., 2015).

Twelve papers were, initially, removed for the following reasons:

- a theoretical discussion of the rôle of memory (Ball and Little, 2006)
- an analysis of pharmacological treatments of addiction (Cutler, 2005)
- the study of active alcoholism and not recovery (De Visser and Smith, 2007; Milliard, 2006)
- an exploration of the sense of "self" as expounded by William James (Gray, 2005)
- an analysis of recovery within in-patient treatment and detoxification settings (Roehrich and Goldman, 1993; Shaw et al., 1998)
- a study of vulnerability during the acquisition of addiction (Valtonen et al., 2009)
- a book summarising theories of recovery/relapse derived from observation (Vaillant, 1983).

The theoretical discussion of Meisel and Karlawish (2011) was deemed unsuitable because of its theoretical nature, even though it argued for including narratives of lived-experience alongside scientific data as a means of expanding the ATRF's understanding of addiction, rather than viewing self-reported data as being merely

anecdotal. Other theoretical papers of Doukas and Cullen (2009), debating the validity of the terms "recovered" versus "recovering" (when linked to personal identity) and the literature review of Sanders et al., (2014), exploring the effects of gender on acquiring spirituality within AA, I omitted as not germane.

Two papers (Bone et al., 2011; Elsheikh, 2008) were removed because their analysis of recovery/relapse was culturally specific. The former examined the rôle of support and sustained well-being among native-Canadians, recovering from volatile substance-dependence, whereas the latter focused on Islamic prayer as being fundamental to recovery for Arabic drug-using males. Hansen et al., (2008) was rejected as they championed the application of specific treatment-modalities, although they acknowledged that recovery was aided by mutual-help groups. Once the transformation (through learning from relapse) was made into a state of recovery, they opined that relapse was not "*feasible*," being purely a matter of individual choice (Hansen, ibid: 268).

Longitudinal surveys, either research-designed (Levy, 2008; Brown, Trinkoff and Smith, 2003; Koski-Jännes and Turner, 1999); or drawn from wider, epidemiological (Pilowsky et al., 2013); national (Laudet and Hill, 2015); or US Veterans Associations studies (Laudet et al., 2014), were sympathetic to the need to *give voice* to what was perceived as a marginalised cohort of recovering-alcoholics (and addicts). Brown, Trinkoff and Smith (ibid) explored the specific problems of stress and drug-availability amongst drug-recovering nurses and Levy (ibid) identified the presence of gender-specific relapse-triggers and decreases in executive control and decision-making, intimating that relapse related to an erroneous belief in personal control. Pilowsky et al., (bid) suggested that it was not the volume but the specificity of stress which precipitated relapse. Laudet and Hill (ibid), using a uniquely US phenomenon (i.e. US Veterans Associations), compared treated with non-treated addicts, recognising that most research is conducted with treatment-seeking persons and concluded that non-treated addicts were more likely to access mutual-help groups such as AA.

Koski-Jännes and Turner (1999) noted similarities between acquiring addictive behaviours and relapse precipitants, but equally avowed that recovery-narratives (between substances) varied significantly. This called into question the validity of comparing lived-experience between addictions (DiClemente, 2006). However, in

these surveys, where response options were often restricted to Lickert-type answers to researcher-devised, pre-formulated questions, followed by quantitative multivariate analyses, they could hardly be considered as encouraging participant self-reflection (Conners and Franklin, 2000).

All were omitted as not being, authentically, indicative of personal expressions of lived-experience. Furthermore, from a *clinical perspective* it is a recognisable feature of alcohol-treatment that the incidence of post-treatment relapse, across time, is neither stable nor linear (Mertens et al., 2012). Consequently, representing an individual relapsing within 12 months of discharge as being equivalent to someone who relapses several years later, may capture some, but ignores many of the important aspects of treatment-outcome (Pilowsky, ibid). Four surveys, drawn from affiliates of AA were at this stage retained. 21 papers, in total, had been omitted.

4.5 Assessing the study quality of the remaining 56 papers

As recommended by Boote and Beile (ibid), papers were grouped by methodological approach, with attention paid to the data-source, i.e. whether data was derived from life-narratives of recovering-alcoholics (untainted by other addictions or comorbidities serving as potentially confounding variables) or some other researcher-driven means.

Though phenomenological research was popular, ATRF research continues to be dominated by traditional approaches favouring cross-sectional or observational/cohort studies, longitudinal/prospective studies and surveys, which comprised 62% of the remaining papers (see Table 1 below).

Table 1 **Methodological Approaches**	**Papers**	**% (100)**
Cross sectional/observational	18	32
Longitudinal/Prospective	13	23
Phenomenological	13	23
Grounded Theory	5	8.5
Surveys	4	7
Case Study/Vignette	3	5
Heuristic	1	1.5
Total	**56**	**100%**

Having delineated the corpus of research material for my review, I first attended to two papers within it, which questioned the influence of culture and gender as potential sources of bias.

4.6 <u>The cultural bias of North America</u>

Lillibridge et al., (2002) argue that the bulk of ATRF studies originate within North America, where study participants are drawn from a cultural milieu of poor socio-economic and educational backgrounds with additional social problems, e.g. poly-drug use, unemployment, homelessness, etc., (Laudet and Hill, 2015) and where participants are regularly mandated by courts to seek treatment. They suggest such coercion and concomitant social problems makes like-for-like comparison between studies difficult. 50% of the remaining papers originated within America (excluding Canada) and a significant proportion fell into this category. At this stage of my selection process, this was not felt to be grounds on which papers should be set aside (see Table 2 below), but attention would be paid to their composition of participant sampling.

Table 2 **Geographical origins of research in all remaining 56 papers**	**Papers**	**% (100)**
USA	28	50
UK	13	23
Canada	5	9
Sweden/Finland/Denmark/Norway	5	9
Hungary	2	3.5
Australia	2	3.5
Germany	1	2
Total	**56**	**100%**

4.7 Gender Bias

Sanders et al., (2014) hypothesise that the representativeness of research is questionable, due to a gender-bias towards male participants and where women's needs are largely ignored (Brewer, 2006), specifically women attending AA whom, they argue, suffer additional feelings of powerlessness, as members of a patriarchal grouping founded by men (Matheson and McCollum, 2008). Within this review, a study by Bond and Csordas (2014) found no significant weight for this latter argument.

Their female only study (*n* = 10) interviewing recovering alcoholics (3 years) found that, in the context of recovery, an admission of powerlessness as *agency* was not equivalent to powerlessness experienced in other areas of their participants' lives. This meant that participants accommodated powerlessness to their own healing-process, via the 12-Steps, as a means of self-empowerment (i.e. Step 1, gaining power by letting go of the illusion that they controlled their alcoholism).

AA empowered them to make new choices by developing self-awareness and self-knowledge (i.e. knowledge is power). This led to increased feelings of self-acceptance whilst removing notions of docility. Some women, therefore, could intervene and create a world of recovery, which was not perhaps fully designed for them, by recognising the notion of *surrender to win* (Step 2), as being part of their increased

agency, taking responsibility and gaining control of the self. Surrender/powerlessness meant getting rid of the self-destructive and self-repressive burden of addiction.

My review did not, specifically, seek to identify instances of gender-bias. Within those papers reviewed, the split between female-only studies and those having more female than male participants (43%) outweighed male-only studies, or those which had a higher preponderance of men (37.5%). This suggests that, within my study, each gender was being represented with equal consideration (see Table 3).

Table 3 **Gender split of participants in all 56 remaining papers**	**Papers**	**% (100)**
All Female	10	18
All Male	7	12.5
More Women	14	25
More Men	14	25
Equal Weighting	2	3.5
Not Stated	9	16
Total	**56**	**100%**

4.8 Preliminary observations

Before reviewing each research methodology, I include some general observations. Whilst researchers were assiduous in acknowledging their sources of funding, the same could not be said for indicating whether their study had gained ethical approval. 52.6% of studies did not state whether (or not) this had been granted. Where data was drawn from national studies, this could be implied and for the single heuristic study this was not required.

Despite the fact that the majority of papers originated from North America, the use of DSM 5 (or its antecedents) as diagnostic criteria was not prevalent. Phrases such as "*problematic drinking*" (Connors et al., 1988); "*newly recovering-alcoholics*" (Dunlop and Tracy, 2013); or "*poly-drug users*" (Laudet, 2007) made deciding if the participants

were alcoholic difficult. Where ambiguity prevailed the paper was, ultimately, rejected.

It was also noted that, in order to aid rigour to their research methods, only two papers (Hibbert and Best, 2011; Nordfjærn et al., 2010) pre-tested the feasibility of their research-methods by the use of pilot studies, as suggested by Leon et al., (2011).

4.9 The methodological analytical review

This section identifies each methodology in turn; the papers included within it; and critically analyses the approach to lived-experience against my study's inclusion and exclusion criteria.

4.9.1 Cross-Sectional, Cohort Observational Studies (18)

Best et al., (2012); Bond and Csordas, (2014); Brewer, (2006); Brooks et al., (2013); Green et al., (1998); Halonen, (2006); Hammer et al., (2012); Hänninen and Koski-Jännes, (1999); Hibbert and Best, (2011); Hoffmann, (2003); Kelemen et al., (2007); McIntosh and McKeganey, (2000a); Neale et al., (2015); Nordfjærn et al., (2010); Rushing, (2008); Steffen, (1997); Takeda et al., (2013); Wasmuth et al., (2014).

Within these qualitative cross-sectional/observational studies, citing previously established empirical research as the *raison d'être* for current investigation, the narratives of lived-experience, *qua* experience were used to aid analysis and diagnosis of various states of the recovery process (Halonen 2006). Analytical techniques spanned: narrative inquiry (Brooks et al., 2013); interview analysis (Halonen, 2006); thematic analysis (Wasmuth et al., 2014); narrative therapy and content analysis (Hammer et al., 2012); qualitative content analysis (Kelemen et al., 2007); and narrative analysis (Steffen, 1997).

In some cases, recovery appeared synonymous with abstinence (Green et al., 1998) and the sustained control over the use of a substance. With McIntosh and McKeganey

(2000a), a study of *n*= 70 drug-users, a person could be deemed to be in recovery whilst, permissively, still using cannabis. Sustaining recovery, by formulating a new recovery-identity, could lead to an improved quality-of-life (Hibbert and Best, 2011). In AA terminology, this quality may be termed "serenity", being an orientation of life involving the transformation of the self along spiritual lines (Rushing, 2008). However, the career path of recovery is rarely linear or ideal, as even some AA affiliates spiral out of their recovery career in a never ending cycle of relapse/recovery (Hoffmann, 2003).

Confusingly, in other papers recovery appeared to be used, synonymously, with relapse-prevention (Kelemen at al., 2007) being allied to an individual's personal goals, though not always involving abstinence (Neale, et al., 2015), even though relapse was regarded as a failure to cope with negative life-events (Nordfjærn et al., 2010).

Steffen, (1997), suggested that narrative life-stories could be viewed as *illness narratives*, rarely constant and incomplete, but which provided insights into the relationship between reality (the life lived) or experience and its expression (the life as it is told). Consequently, the life-story became an organisational structure, rather than a rigid framework producing a stereotypical story. However, Steffen (1997) affirmed that each unique life-story became a representative of every other life-story and thereby ceased to be subjective. Hänninen and Koski-Jännes (1999) studying *n*= 51 poly-drug users, reduced these stories to five identifiable types. Brewer's (2006) all-female study (*n*= 11 self-labelled alcoholics) supported the application of 12-Step recovery and abstinence and the idea that a life-story was an organisational structure, but argued for the particularity of contextual factors which shaped the story as the predominant experiences, for her participants, were as victims of childhood sexual-abuse.

The analysis of lived-experience, via this methodology, was used by professional clinicians to establish a causal nexus between the triggers (feeling-states or events), which then precipitated the relapse event (Takeda et al., 2013). It could then be argued that, for the majority of cases, the subsequent treatment intervention was suitable in dealing with those antecedents (Brooks et al., 2013). The lived-experiences of recovery and relapse were re-framed, either through accepted models of change (e.g. the Transtheoretical Model of Change), or by researcher-guided interpretations

such as *addiction-as-occupation* (Wasmuth et al., 2014), which may have intuitive appeal, but conveniently allowed for occupational therapists to stake their claim to the treatment of addiction, but which is not a recognised addiction-treatment modality (Castonguay and Beutler, 2006).

I rejected this grouping of papers on three grounds. First, only four papers (Steffen, 1997; Brewer, 2006; Hibbert and Best, 2011; and Bond and Csordas, 2014) involved participants whose primary and only drug-of-choice was alcohol. With other papers, participants frequently used a plethora of other drugs (Hänninen and Koski-Jännes, 1999), including heroin (Best et al., 2012), or methadone (Hammer et al., 2012). Secondly, abstinence, or the non-use of a substance, was ill-defined and participants were drawn from in-patient treatment-settings (Green et al., 1998; Nordfjærn et al., 2010; Neale et al., 2015) or had been sober for as little as one week (Brooks et al., 2013). In one case "abstinence" was only achieved through the substitution of another drug (Best et al., 2012).

Thirdly, whilst Takeda et al., (2013: 418) suggest that to understand the process of relapse would, "*benefit from eliciting and exploring service users' detailed accounts of relapse*," the lived-experience of relapse was reduced to the level of reified, impersonal data to elicit hypotheses as to the nature of the recovery process and so bolster treatment techniques, which aided the prevention of consumption. No attempt was made to *give voice* to the participants or to view their experiences of the relapse phenomenon through their eyes.

One significant point, raised by Hammer et al., (2012), suggested that narratives are not necessarily related to the substance *per se*, but relate to the experience of using that substance. This could involve the use of highly eidetic metaphors which, they argued, are important to explore. They concluded that alcoholism, "*is protean, such that if we try to reduce its character to one nameable form, with one "unified theory", we will have failed to address it in its entirety*" (Hammer et al., 2012: 732). Unlike Steffen (1997) I would agree that experiences of alcoholism should not be reduced or considered "unified" or "typical". The potential importance of metaphor as an elucidation or window into experience chimed with both my pilot study (see Chapter 7) and my own clinical practice.. (I address this further in Chapter 8: Methods of Analysis).

4.9.2 Longitudinal/prospective studies (13)

Connors et al., (1988); Dennis et al., (2007); Dunlop and Tracy, (2013); Helm, (2016); Laudet, (2007); Lloyd, (2002); Murphy-Parker and Martinez, (2005); Orford et al., (2006); Scott et al., (2005); Tate et al., (2006); Vaillant, (1988); Vaillant, (2003); Vuchinich and Tucker, (1996)

Longitudinal studies illuminate how the process of recovery develops during a person's lifespan. These papers ranged from: three months, analysing nurses' experience with addiction/relapse (Murphy-Parker and Martinez, 2005); six months, exploring the effects of personal choice on relapse (Vuchinich and Tucker, 1996); three to twelve months, exploring client experiences of change within treatment (Orford et al., 2006); one year, measuring the effects of stress (Tate et al., 2006); two years, analysing drinking expectancy (Connors et al., 1988); and the therapeutic rôle of AA (Helm, 2016); six to thirty-five months, studying the transition-cycle within relapse (Scott et al., 2005); 4 years, researching the effects of self-redemption narratives on relapse-prevention (Dunlop and Tracy, 2013), 8 years, studying the effects of abstinence (Dennis et al., 2007); 12-20 years, researching preventative factors to relapse (Vaillant, 1988); and 21 years, in a study related purely to doctors and medical professionals, which highlighted that, if unchecked, alcoholism is terminal (Lloyd, 2002). Other studies (one month to 3 years), examining the lived-experiences of recovery/relapse and a person's affiliation with AA, also, confusingly, included participants for whom heroin and crack cocaine were their principal addiction (Laudet, 2007).

The longest prospective study (60 years) and one regarded as having seminal importance, focused on white males' primary use of alcohol, but not on people who self-identified (or were diagnostically diagnosed) as being *alcoholic*, but instead *abused* alcohol which, in some cases, ultimately lead to *alcohol-dependence* (Vaillant, 2003). His research engaged with a group of Harvard undergraduates (*n*= 268) and compared them, over the study's duration, with non-delinquent, but socially disadvantaged, city adolescents (*n*= 456). Interestingly, it concluded that less-advantaged participants (with a history of dependence) were more likely to achieve abstinence, whereas

higher-educated men (with good social support) were more likely to remain chronic alcohol-abusers for longer.

Studies using this methodology were omitted because the primary purpose of prospective studies, especially when commencing from in-patient status, was to use their findings to identify preventative measures of relapse i.e. coping-strategies (Connors et al., 1988), or analyse the predictive value of specific relapse triggers which could validate any on-going treatment. Definitions of abstinence were varied and operationalised as not-drinking, heavy-drinking and light-drinking (Vuchinich and Tucker, 1996).

Interestingly, most studies addressing the lived-experience of recovery, accepted the need for social-support and particularly from mutual-help groups. The ability to construct a life-narrative which made sense or gave meaning to a life of self-destruction was viewed as necessary to the therapeutic healing-process. Meaning-making was frequently construed as identity-transformation (e.g. Dunlop and Tracy, 2013), though the mechanisms by which this was achieved appeared shrouded in mystery. The purpose of such studies became a demonstration of how a particular intervention influenced the process of sobriety/recovery and how this altered during the lifespan (*post-partum*) of a recovering-alcoholic/addict.

4.9.3 Phenomenological Studies (13)

Chappel et al., (2006); Flaherty et al., (2014); Larkin and Griffiths, (2002); Lillibridge et al., (2002); Matheson and McCollum, (2008); Nixon and Solowoniuk, (2005); Nixon and Solowoniuk, (2008); Rácz et al., (2015); Shinebourne and Smith, (2010); Shinebourne and Smith, (2011); Smith, (1998); Weegmann and Piwowoz-Hjort, (2009); Zakrzewski and Hector, (2004)

Whereas other methodologies take an aseptic view of lived-experience, (i.e. where narrative-data is only used in as far as it bolsters, affirms or refutes the ATRF's various and established empirical approaches to alcoholism-treatment), a phenomenological methodology argues for the incorporation of the *voice* of people under study (Larkin

and Griffiths, 2002), even if the sound of that voice is that of an expert researcher (e.g. Larkin et al., 2006). Their study, using Interpretive Phenomenological Analysis (IPA), argued that subjective-accounts can inform the relationship between addictions, self and identity. However, their data-source was drawn from observations made with addicts (*n*= 13), not purely alcoholics and within an in-patient treatment setting, where the participants had yet to achieve any form of longer-term recovery.

Confusingly, while the premise of phenomenology is to "*preserve the uniqueness of the experience*" from the participants' point of view (Smith, 1998: 1), its hermeneutical process of analysis reduces the self-reporting of that experiencing to a group of themes, so that what is being observed is transformed into an "*emerging common structure*" (Flaherty et al., 2014: 350). Some papers referred to this (e.g. Nixon and Solowoniuk, 2008) as being the "essence" of the phenomenon but it appeared to be little more than a general application of the theme(s) to *all* participants, irrespective of whether they had experienced them or not. In short, an intrinsically subjective experience, by this methodology's process of elucidation, becomes objectively commonplace. In some cases, the findings were so vague, e.g. making AA part of recovery; extending recovery into the daily routine of life; and exercising self-care, (Shinebourne and Smith, 2011) that they ceased to be unique, being no different from the quotidian practises expected from AA members (AA, 1976).

Potentially, I believe that an inherent flaw, within hermeneutic phenomenology, is its use of coding in order to arrive at (codified) themes (whether defined as essential or incidental), which inevitably presents the reader with an aggregate description of experiencing. It may be argued that such themes adequately, even sympathetically, reflect the collective experience of all the study's participants (however tangentially), but the unique voice of an individual essentially disappears. This may be achieved when the researcher, following a Gadamerian application of hermeneutics, acknowledges "*his (sic) own background and indeed uses it in collecting and interpreting data*" (Smith, 1998: 214). Alternatively, so as not to, "*impose his or her assumptions or biases*" either onto the participants or the analytical process, the researcher "*brackets*" those prejudices, in a Husserlian-fashion (e.g. Zakrzewski and Hector, 2004: 65), yet without explaining how this is, realistically, achieved.

Additionally, by following the ATRF's approach to studying all types of addiction *en masse* study cohorts are, from the outset, rarely homogenous. For example, Weegmann and Piwowoz-Hjort (2009) engaged with *n*= 8 recovering alcoholics to examine their on-going relationship with AA as it affected their recovery. But then, without explanation, included *n*= 1 abstinent drug-addict, who did not attend his corresponding fellowship-group, Narcotics Anonymous. Yet, they still felt able to conclude that with *all* 9 participants, they could discern a "general style" of approach, which harmonised with established empirical research.

However, it is more difficult to suggest or assume that each participant, in any study, has experienced each theoretical theme in precisely the same way, with the same degree of intensity, or even that it has any relevance at all. Yet, in many of the discussion sections of papers (e.g. Nixon and Solowoniuk, 2008) the emergent themes are cheerfully applied to all participants as if each was in full agreement. In other words, the hermeneutic process of reductive coding (whether intended or not) serves to create a collegial expression of experiencing which, ultimately, makes no distinction between the individuality/uniqueness of the participants.

An additional flaw exists whereby a theme (being at times so abstract, yet presented as authoritative fact, if for no other reason than it has emerged from the analysis of a self-reported narrative) becomes, in itself, a qualitative form of diagnosis or labelling, with attendant and inferred negative judgements. For example, Larkin and Griffiths (2002: 310) concluded their study by stating that, "*a positive orientation towards the future must be conducive to successful change*" and further suggested that to achieve this, problem users *must* receive professional, psychological support. Conversely, it may be assumed that those who are unable to afford or access psychological support are, perhaps, doomed to failure.

Experiencing takes place over time, yet an interview can only provide a snapshot of one brief expression of experience, voiced on a specific date and under an essentially artificial mode of encounter, i.e. a recorded and transcribed narrative. But the researcher's reflection on this single encounter becomes the primary means of discovering the "essence" or meaning of the experience (van Manen, 1997/2015) and, because that essence is presented as a thematic distillation, it inevitably ceases to be

unique but becomes generalised. The classification of themes is helpful, but the danger is that they may also become authoritative.

Using research to improve treatment-interventions makes inherent sense. A therapist can identify (from a researcher-interpreted narrative) elements of experiencing given thematic labels which may resonate with similar concepts regularly addressed by treatment modalities. But, as Prufrock laments (Eliot, 1954), this does not mean that a theme accurately reflects or captures the meaning of lived-experience, as it was originally expressed.

For example, Smith's (1998) hermeneutic phenomenological study (with problem drinkers) found that *suffering* (especially from alcohol withdrawal) was a key theme of his study. Therapeutically, the notion of *suffering* can be addressed by various professional modalities. But not all his participants experienced the sub-themes which lead to his conclusion, or described their experiences by such a term; he also synthesised the experiences of men and women without any reference to gender difference. Furthermore, a person in longer-term recovery will not experience the aversive effects of alcohol withdrawal.

The difficulty arises if and when such themes become treated as empirical fact which can then be universally applied, aided by the fact that this methodology (by nature of its orientation towards the meaning of lived-experience) carries with it, perhaps, some implied *gravitas* not, presumably, found within other research methodologies. This can be further strengthened (when taking an Heideggerian approach) which suggests that, each person's *being-in-the-world* exists within a wider cultural lifeworld, which imbues it with a cultural meaning and shared understanding. However, as the basis for their study, Rácz et al., (2015) cited the previous findings of the cross-sectional/observational study of Hänninen and Koski-Jännes, (1999) (see above) and the grounded theory of McIntosh and McKeganey (2000) (see below) both of whom argued for the need to form a new identity within the recovery process. Mercurially, all three methodologies reached nearly identical conclusions.

Within this phenomenological category, only three papers primarily studied the effects of alcoholism, potentially confirming DiClemente's (2006) assertion that the ATRF's study of addiction follows an, ubiquitously, aggregate approach. These studies

included: Smith (ibid), (see above) whose UK-based study participants (*n*= 6) were equally split between genders, but were drawn from an in-patient treatment-setting; the study of Weegmann and Piwowoz-Hjort (2009) exploring identity re-construction within mutual-help groups and was weighted towards alcoholism (*n*= 9 AA affiliates with between 9-23 years sobriety and *n*=1 recovering drug addict); and Zakrzewski and Hector (2004) who focused on male-only experiences of current addiction; AA's rôle in creating a sense of personal transformation; and the need to change. They were not germane to my research, as they studied the early acquisition of recovery.

Papers addressing gambling-addiction (Chappell et al., 2006: Nixon and Solowoniuk, 2005) were omitted, even though DSM 5 regards gambling as possessing similarities of cognition and behaviours with substance addiction. But my study concentrates on relapse to re-using a substance, not a behavioural-addiction. Papers exploring the lived-experience of recovery from non-prescribed drugs or poly-drug use were also omitted (Flaherty et al., 2014; Lillibridge et al., 2002; Shinebourne and Smith, 2011; Rácz et al., 2015) as being unrelated to alcoholism.

With Flaherty et al., (ibid), even though participants were abstinent, the group's composition was formed of a curious mixture of conflicting ideological approaches to recovery, including: established mutual-help groups; medication-based or secular approaches; and even "natural recovery". This study's drive to secure "essence" meant that this disparity was easily overlooked. Nixon and Solowoniuk (2008) exploring the experiences of *n*= 10 participants who were "addicts" was also omitted. Their study was not germane as it centred on people who had, purposefully, disengaged from the 12-Step fellowship as no longer satisfying their recovery needs and eschewing its ideology.

No phenomenological paper explored the rôle of relapse, *per se*, within the life-experience of a recovering-alcoholic. This was to be expected because, as previously noted, ATRF research focuses on problems with *addiction* of which alcoholism plays only a part (Cook and Reuter, 2007). Secondly, as with other methodologies, phenomenological studies appear to be driven by a (generalised and transferable) explanation of experiencing, which informs professional interventions addressing all addictions. What my study seeks to achieve is to garner subjective descriptions of what it is like for an alcoholic to have relapsed, in the context of his/her recovery, (i.e.

from his/her frame-of-reference) so that personal meaning (as it affects his/her self-construct) is perhaps more closely discerned by those intrinsically idiosyncratic experiences, which are *not* shared with other participants.

Obvious commonalties exist within experiencing, most notably temporality, as relapse is an event-in-time, located within a person's lifespan (Sugarman, 2001). A time exists before relapse; during the event itself; the immediate consequences of consumption; and the longer-term assimilation of the experience into an on-going recovery-process. An alternative phenomenological method of gaining an understanding of relapse within the lifespan of recovery (and which avoids thematic coding), would be to examine the use of eidetic metaphors within the description of the event.

There are those, (e.g. Paley, 1997, 1998 and 2005) who argue that the followers of IPA, especially within the nursing community, neither understand nor faithfully apply the philosophies of Husserl, Heidegger or Gadamer to their research and so yield defective results. Others (e.g. Earle, 2010) suggest that such philosophy (and she includes Merleau-Ponty) was not intended to provide rules or procedures for conducting research. This thesis does not propose to enter into that debate. It is sufficient that those researchers (who presented IPA studies within this review) believed that, in fact, they were executing their methodology in a sound, rigorous way.

IPA was rejected, not because of any imperfections with its philosophical underpinnings but, principally, on the presentation of the researchers' findings with their emphasis on the primacy of researcher-intuited themes, which was contrary to my objective. Though IPA opined a desire to give pre-eminent voice to individual participants, the subjective voices of participants were largely ignored, by being subsumed into themes which had a general application.

4.9.3.1 <u>The rôle of metaphor in elucidating lived-experience</u>

However, two papers, (Matheson and McCollum, 2008; Shinebourne and Smith, 2010) although creating researched-interpreted themes and at variance with my study's alcohol-only criteria, appeared significant, as they addressed the use of metaphor as a means of unlocking a narrator's attempts to symbolise the phenomenological felt-

sense of addiction/relapse. The cross-sectional studies of Hammer et al., (2012) and Helm (2016) (see above) had hinted that exploring eidetic metaphor could yield positive insights into the relapse-experience. In other words, the study of metaphor was phenomenological, but not restricted to the area of a single phenomenological methodology. Likewise, AA (1976) describes, metaphorically, both the phenomenon of *alcoholism* and what it means, phenomenologically, to be *alcoholic*.

Though a highly personal state-of-being, illness can be modelled metaphorically (Semino, 2008), though not all metaphorical descriptions of alcoholism are helpful (Sontag, 1979), so that metaphors may become useful resources which elucidate the phenomenon, but problematic in creating a linguistic construction of the illness. These two points are reviewed below.

Matheson and McCollum (2008), a US-based study, engaged with *n*= 13 predominantly alcoholic women of varied social/racial backgrounds; *n*= 1 viewed her mental health difficulties as being primary, with her drug-use secondary. Their average recovery-time was 9.5 years; and half had relapsed. Combining phenomenology and "*feminist theories*" (ibid: 1028), their study explored AA's metaphorical use of *powerlessness* (Step 1) and how this was experienced within recovery. Traditionally, the acceptance of the twin metaphors of powerlessness and unmanageability (their study did not consider the latter) are essential requisites to engage, comprehensively, with AA's recovery programme (AA, 1976).

Their findings suggested that, for some women, metaphors imposed by the (patriarchal) ideology of AA were unconducive to recovery or were at the least paradoxical. For some, powerlessness evoked positive emotions (e.g. relief), being an easy concept to embrace, especially where life was felt to be out-of-control or their addiction was severe. For others, who felt that their lives were successful, except for a few areas where alcohol/drugs were problematic, it indicated negative emotions (e.g. fear).

Shinebourne and Smith (2010), a UK-based study, investigated the use of eidetic metaphors in expressing what it meant to be an addict. *n*= 6 female-only participants, at different levels of active-alcoholism/addiction and recovery (only *n*= 1 had been abstinent and for three months), employed a variety of metaphors (e.g. pain, suffering,

the void, “boxing” emotions, the battle) to describe the existential, felt-sense and psychological aspects of drug/alcohol dependency. This study suggested participant metaphors communicate both feelings and cognitions involving a multiplicity of meanings but, I noted, assumed that the participants’ metaphors were eidetic whereas some were derived from AA.

Matheson and McCollum (ibid) argued that a researcher may, potentially, exhaust the meanings of an applied metaphor by inductive reasoning. Their participants’ absence of sustained-sobriety prevented them from discovering whether the use of metaphor changed over time and what metaphors could be helpful in expressing longer-term recovery. Shinebourne and Smith (ibid: 66) countered that “*metaphors may overshadow and conceal other possibilities*” of meaning. Citing seminal works by Lakoff and Johnson (1980) and Kirmayer (1992) they suggested that metaphors not only conveyed multiple-meanings, simultaneously, but also secreted emotions which were too painful to address. Equally, metaphors could serve as ways of expressing the spiritual nature of one’s being, even though this may not be totally comprehended.

Acknowledging that relapse was ubiquitous and needed to be avoided, both papers left the phenomenon unexplored. As with other phenomenological approaches, the use of metaphor only served to aid the establishment of collective themes, rather than highlighting the unique experiences of individual participants.

However, I suggest that these two studies mark a way to discriminate whether my participants’ narratives were pre-rehearsed or spontaneously idiosyncratic. AA encourages storytelling as part of its healing-process (Dunlop and Tracy, 2013) so that, perhaps, AA affiliates become skilled in presenting a version of events which confirms their acceptance of its ideology. If, as AA members, their use of metaphor can be evidenced as being drawn from AA’s published literature, then this would suggest that the recovery-narrative is prepared as conforming to the social-control of the group (Moos, 2007a, 2008) and, as Matheson and McCollum (ibid) suggest, its exploration as a means of, comprehensively, illuminating the personal experiences of relapse may be questionable. If, however, a narrative utilises eidetic metaphors, then this may suggest that the metaphor may give genuine glimpses into the personal meaning of relapse, thus confirming Shinebourne and Smith’s position.

4.9.4 Grounded Theory (5)

Brudenell, (1997); DeLucia et al., (2015); Masters and Carlson, (2006); McIntosh and McKeganey, (2000a); Orford et al., (2006)

My study does not seek to use recovery-narratives to create substantive, general theories concerning alcoholism which are created, solely, by the inductive interpretation of the researcher(s). In most papers, the choice of a grounded theory method was mainly that of Glaser and Strauss (1967), with the exception of DeLucia et al., (2015) which did not explicitly state which variant of grounded theory it was employing.

Brudenell (1997) engaged with *n*= 11 women to explore their concurrent use of alcohol and drugs during the transition to motherhood and their means of relapse-prevention. She concluded that the keystone protective strategy was that of *balancing* the needs of being a parent at different stages (from conception to birth and motherhood) with the needs of being in recovery. This was a specifically focused study which, having little general application, was not germane to my research.

DeLucia et al., (2015) involved *n*= 21 participants, 60% of whom were in recovery from heroin-use. Whilst recovery involved the use of a 12-Step programme and was abstinence-based, this study concentrated on aspects of the recovery process and not relapse which, as a construct, was never mentioned.

A female-only study, Masters and Carlson (2006), interpreted their data to create a substantive theory of the experiencing of connectedness and disconnectedness which dominated the recovery-process amongst *n*= 12 women. Six members of this cohort had more than five years of recovery, compared with six who were still undergoing treatment. Participants were all involved in drug-alcohol treatment programmes and were not solely alcoholic.

McIntosh and McKeganey (2000a) recruited *n*= 71 UK participants (60% heroin users) and examined recovery-strategies employed to predict and avoid relapse. The study concentrated on addiction where, in some cases, recovering participants were non-using and others were, "*confining their drug-use to cannabis*" (p 180). Defining what

was meant by the term *recovering addict* was left to a participant's own view point. As with DeLucia et al., (ibid) research into a broad *aegis* of addiction was accepted. Problematically for my study (which follows a strict definition of abstinence), the strategic use of alcohol, prescription drugs and non-prescription drugs as a means of achieving an "alternative high" for a primary drug-of-choice was viewed as a legitimate, though risky, means of recovery.

Orford et al., (2006) a longitudinal survey using grounded theory (Glaser and Strauss, 1967), aimed to develop a substantive model for change amongst *n*= 211 mainly male recovering-alcoholics. Using data from the UK Alcohol Treatment Trial (of 2001/2005), unrelated to long-term recovery, it made no distinction between attributed causes or triggers to relapse and concluded that unaided change happens more frequently than when therapist lead. Recognising that there was no tradition for incorporating participant lived-experience with treatment outcome research, it provided no explanation for relapse.

These papers were omitted. They followed a methodology designed to develop substantive theories derived from the interaction between researcher and participant. They also focused on the broad understanding of addiction, as being vicariously applied to all dependence-inducing substances, exploring the nature of recovery, but shedding no light on the subjective experiencing of relapse.

4.9.5 Surveys (4)

Gomes and Hart, (2009); Kairouz and Dubé, (2000); Seneviratne and Saunders, (2000); Walters and Gilbert, (2000)

Due to their increased sample-size, surveys imply that their findings capture a broader, representative flavour of participant attitudes towards a subject than could be achieved within an observational study, employing a correspondingly smaller sample group.

The British study by Gomes and Hart (2009) tested the idea that physical abstinence and psycho-existential well-being (during *post-partum* aftercare) were enhanced by greater compliance with AA's prescribed practises. Participants (*n*= 76) were assessed two years after discharge from a 12-Step rehabilitation programme. The cohort was divided between those continuously (or nearly continuously) abstinent and those frequently intoxicated (at least 3 days out of 10 days) within the past 90. Subjective quality-of-life was defined as the absence of anxiety and depression (i.e. psychosocial well-being) and a high level of personal meaning-in-life. In short, UK participants' responses were used to test a hypothesis that contrasted with US research findings, using a post-test-only design (with yes/no answers) and multidimensional analysis. The study aimed to elicit which aspects of AA's practice and recovery activities were most efficacious.

Kairouz and Dubé (2000) sought to test the difference between personal perceptions of well-being amongst abstinent-alcoholics (*n*= 81; 41 months average length of abstention and experiencing one relapse) against social equivalents among a comparative, though disparate, group of non-alcoholic nuns, university women and male police officers. Alcoholics were given a 10-point questionnaire completed with Lickert-type answers, which were analysed using a Pearson correlation analysis. They concluded that alcoholics positively associated length of abstinence with well-being; the 3 non-alcoholic groups evaluated an abstinent-alcoholic more highly than a non-abstinent one.

Seneviratne and Saunders, (2000) surveyed *n*= 70 alcohol-dependent inpatients relative to their demographic details, drinking history and levels of dependence, to explore the difference between personal attributions for relapse, versus the attribution for relapse in other people. Their purpose was to advance the case for using attribution theory (Jones and Davis, 1965) to any model of relapse which was based on self-report, especially in the area of high-risk external triggers which precipitated relapse. This, they concluded, may be a consequence of the attribution process rather than the true cause of the relapse. As with the previous surveys, lived-experience data was used to test an hypothesis.

Walters and Gilbert, (2000) using an anonymous survey, championed the concept of *addiction-as-occupation.* Using *n*= 31 male participants, enrolled in a drug-education

class, they contrasted their definition of addiction with the views of *n*= 20 professional addiction "experts". There was a divergence of opinion, whereby addicts focused on feelings such as needs and urges, whereas "experts" concentrated on the compulsive aspects of behaviour, the presence of physical dependence and diminished control.

Papers deriving an understanding of lived-experience from surveys were rejected, because surveys reduce the complex richness of experience into sterile statistical data, used as evidence to prove/disprove an hypothesis. As previously stated, Lickert-type answers do not allow for depth of thought and reflection and, as Kairouz and Dubé (2000) and Walters and Gilbert (2000) indicated, the wording of the questions posed could easily steer a participant to answer in a way in which s/he thought was most wanted. To describe a survey's findings as examples of lived-experience is a misnomer but is, perhaps, used quite cynically to authenticate an hypothesis as being empirical fact.

4.9.6 Case Study/Vignette (3)

Khantzian, (2011); Kubek, (2007); Tiburcio, (2008)

Khantzian (2011) acknowledged the work of Marlatt and Gordon (1985) in identifying intra- and interpersonal factors which triggered relapse. He sought to inform the experience of relapsing, via a psychodynamic perspective. Narrative data was derived from a group-session processing the relapse of "David", an alcoholic, attending a 30-day residential rehabilitation-programme. "David" joined AA, maintained his abstinence-based recovery for eighteen months, but relapsed through the desire to "reward" himself after feelings of success. The group shared their commonalities of experiencing relapse, with attendant feelings of vulnerability and helplessness, but fell short of exploring the phenomenon beyond its trigger-state. What started as a subjective account of experience was transformed into an objective description of group-processing. It also strongly affirmed Khantzian's previous hypothesis (Khantzian, 1985) that alcohol (relapse) is used as a self-medication to restore feelings of self-control.

Kubek (2007) examined the recovering life-story of "Jane", an abstinent drug-user with a co-morbidity of manic-depression, training to be an addiction counsellor and experiencing the stigmatising language of her fellow classmates. Relapse *per se* was not discussed beyond her awareness that it was probable, but not inevitable. Kubek focused on objectifying recovery as a change of identity, which required understanding and social support, instilling within an addict a sense of hope for the future. Relapse was attenuated by constant reminders of the emotional, physical and psychological pain which addiction generated for both the user and her wider environment. It should not deflect a person from the pathway to recovery.

Tiburcio (2008) outlined the life story of "Marisol" a 39 year-old, Hispanic female, ex-heroin and cocaine-user who had been gaoled for possession of drugs and was now in long-term recovery (11 years). The data emerged from a wider study (*n*= 25) which examined the relationship between drug-use and crime. This paper outlined the various desistance strategies which "Marisol" employed to remain in recovery, including her change to a recovering identity, (and positive relationship with self), identifying relapse-triggers and developing a spiritual lifestyle. In particular, it focused on what alternate coping-mechanisms were deemed useful.

These papers were eliminated as, even though they were engaging with the lived-experience of recovering-addicts and alcoholics, this occurred within the usual ATRF context of examining universal triggers to recidivism and coping-strategies to maintain recovery. The overall emphasis was on the techniques of recovery which could be utilised by all those in recovery, rather than describing the phenomenon of the unique relapse-experience.

4.9.7 Heuristic (1)

Merritt, (1997)

This was a frank, autobiographical description of a female recovering-alcoholic, attending AA and utilising the 12-Steps. Merritt revealed her intense feelings of remorse (expressed as guilt) and shame and distinguished between these two

concepts. Guilt was caused by the harm she inflicted on her family, precipitating feelings of having broken her own personal, moral code-of-conduct. This differed from shame where, through her drunken actions, she felt open to the scrutinising judgement of others. Shame meant that she felt demeaned in her eyes and theirs. Guilt (as a moral and ethical compass) could be used (functionally) for reparation and righting the wrongs from the past. This paper was insightful in revealing the experiences of a recovering, abstinent alcoholic, attending AA, but failed to discuss relapse and so was not relevant to this study.

4.10 Chapter Summary (drawing conclusions)

This chapter reviewed seven different methodological approaches to the study of lived-experience. Research into alcoholism is governed by the ATRF's *aegis* approach which studies all addictions *en masse*, thereby failing to discriminate within its participant sampling: the use of assorted drugs; the different stages of recovery/current addiction; what constitutes relapse; differing confounding variables, etc.; thereby making comparison between subjects problematic. Conclusions though tenuous and usually hypothetical, become sedimented as fact. No paper involved participants who conformed to the inclusion criteria for my study.

Furthermore, except for an heuristic account of alcoholism/relapse which is not a mainstream methodology for the ATRF, data of lived-experiences are used to: test hypotheses (observational studies); validate or disprove treatment interventions (longitudinal/prospective); suggest participant-derived, generalisable themes of the phenomenon (IPA); create broad indications of experience from a wide population (surveys); produce substantive theories (grounded theory); and describe the techniques or processes of treatment in real-life situations (case study). Understanding the subjective experience of relapse, within the context of recovery, is absent from the debate.

However, given the problems of accessing participants in longer-term recovery and the operational difficulties this entails, the use of such methodologies has been understandable (Roehrich and Goldman, 1993). Conversely, such methodologies have failed, by the ATRF's own admission, to make any impact in the key issue of relapse

(Truan, 1993). I contend that a major problem within the ATRF is that qualitative research is, at times, misdirected by the need to achieve not just rigour (Sandelowski, 1993), but that it is considered preferable to ensure validity by demonstrating that findings are generalisable and transferable (Schofield, 2002).

This militates against *giving voice* to the uniqueness of a participant's experiences, unless that voice forms part of a chorus and is not a solo aria. I suggest that (funded) research conforms to the cannons of an academical approach which, perhaps, perpetuates the researcher-participant split, as generalised findings, vicariously applicable outside of the study, warrant financial investment. Conversely, co-constructed descriptive accounts of subjective-experience, derived from intense relationships between researcher and participant, are viewed as nothing more than esoteric, un-empirical indulgence (Danziger, 1997)

The current need to address long-term recovery and understand this phenomenon including the rôle relapse plays within it permits, I suggest, a co-constructed approach and one which is experiential and phenomenological. Moreover, in seeking to understand the phenomenon, it attempts to view that experience from a participant's frame-of-reference, where s/he, not the researcher, is regarded as expert, a title s/he has earned through experience (Slade et al., 2012).

Before describing my choice of methodology, Chapter 5 examines the ethical considerations applicable to my study and the means by which I addressed methodological rigour.

5.0 Chapter Five: Ethical Considerations and academic rigour: the use of participant-validation

This chapter consists of three sections. First, I describe those strategies I employed in respect of ethical considerations within this study. Secondly, I discuss how I thought about and addressed methodological rigour i.e. credibility, dependability, confirmability and transferability within my research process. Thirdly, I describe my use of participant-validation or member-checking, to aid aspects of rigour. Although these are each specific areas of consideration, I acknowledge that each is not entirely autonomous, as their individual content forms part of an inter-related whole.

5.1 Ethical Considerations and strategies

5.1.1 Introduction

Norms of human conduct or that which is commonly viewed as morally acceptable or unacceptable are the concern of ethics, especially where demands may be made of participating humans (Timulak, 2005). The moral justification for psychotherapeutic research is that it makes "*a contribution to a greater public good, by easing suffering and promoting truth*" (McLeod, 2003: 175).

The ethical credibility and social responsibility of this study and the perception, by others, that the safety and well-being of its participants and researcher were adequately safeguarded, (in the sense that, at a minimum, no harm came to either party) necessitates that I can demonstrate that my study conforms to the ethical requirements of the Faculty and University wherein it was undertaken. I confirm that research approval was sought from the Ethics Committee of the University of Central Lancashire (UCLAN) (Reference STEMH 294) and granted on 11/03/2015 (see Appendix 1). Compliance with Health and Safety checklists and Risk Assessments were addressed (see Appendix 5).

5.1.2 Theory pertaining to ethical considerations within research

Psychotherapeutic research is "*intrinsically discovery-oriented and critical*" (McLeod, 2001: 13) potentially invading a participant's privacy and, therefore, deemed intrusive. Whilst it may be impossible to design ethically neutral research to address such intrusion, theoretical literature tends to focus on the implications of a narrow set of ethical principles: beneficence; non-maleficence; autonomy; and fidelity (McLeod, 2003). Each of these principles may reflect society's commonly agreed moral values yet, in research practice, decisions will sometimes be made between competing principles (West, 2002).

For example, what Bond (2000) terms *mindfulness* of ethical considerations formed part of my own reflexivity (e.g. the issues of gender and cultural bias reviewed in Chapter 4). The use of semi-structured interview questions posed a particular dilemma. Both were discussed with my supervisory team. Being pre-formed, these questions meant that participant discourses were effectively being steered, by me, from one topic to another (Ryan and Bernard, 2003). Though participants exercised a degree of autonomy (within the confines of the research topic), this was, potentially, at variance with the principle of client autonomy followed by the PCA (Rogers, 1951) and its technique of nondirective interviewing (Rogers, 1945). On the other hand, being pre-formed, questions afforded each participant ample notice of what was being asked, assisting him/her in making an informed choice and, potentially, serving to reduce any anticipatory-anxiety (beneficence and non-maleficence). Ethical research is, therefore, a balance between benefits over harms within particular circumstances.

Additionally, whilst the rôle of practitioner/researcher is complementary, this dual relationship (Pope, 1991) may cause a potential ethical conflict where the one (researcher) acts to gather data to contribute to knowledge and understanding, whereas the other (therapist) acts in the service of well-being for the client (McLeod, 2003). For this reason, participants engaged within this research study were drawn from AA, being vastly different from those clients I encounter within my clinical practice (Morrow-Bradley and Elliot, 1986) and not receiving therapeutic care from me.

On my initial contact with any AA group, I outlined to its members an overview of the aims of my research and ethical issues were explained to ensure that prospective participants were aware of the basis for recruitment. I invited questions. An Information Sheet, (Request for Participation) copies of the semi-structured questions and copy of the Informed Consent Form were left with each group. (Copies of these documents appear in Appendices 2-4). The detailed explanation of the recruitment process is found in Chapter 8.

My final decision to use the PCA, (in itself an example of reflexivity on the ethical integrity within the study) with its emphasis on empathy, unconditional positive regard (UPR), congruence and client autonomy was mediated, throughout the research process, by my membership of the British Association of Counsellors and Psychotherapists (BACP). Its ethical framework (BACP, 2017: 2.5), identifies six core research-related ethical principles including the four, listed above. I list all six, in turn and the corresponding strategies I employed, as a research-practitioner, to address them and so assist my study's ethical integrity and, concomitantly, methodological rigour:

1) **Trustworthiness** (honouring the trust placed in the researcher):

- *ethical approval was sought and granted*
- *the confidentiality of the participants was maintained by disconnecting their identity from research data*
- *written and computerised data was stored confidentially to which only I had access*
- *transcripts were anonymised and accurately transcribed*
- *there was extensive use of a participant's own words and participants validated all findings relating to them*
- *my use of self in co-constructing a non-judgemental, empathic relationship with participants*
- *mutual congruent use of self-disclosure*
- *recognising potential power imbalances and my refusal to accept myself as sole expert*
- *accurate citation of academic sources.*

2) Autonomy (a participant's right to be self-governing):

- *seeking written informed consent*
- *providing an Information Sheet/Request for Participation*
- *providing the semi-structured interview questions*
- *the use of the PCA*
- *mutual selection of time and location of interviews*
- *right of voluntary participation; to halt the interview process at any time; the choice to refuse to answer questions; and withdrawal without explanation or negative repercussion*
- *the right to validate their personal data to avoid misrepresentation*
- *affording time for reflexivity within the validation process to do this*
- *an additional one month "cooling off" period, after data had been reviewed, before agreeing for their data to be include*
- *my trust in the actualising-tendency and ability of each person to interpret and make sense of their experience without researcher-expertise.*

3) Beneficence (promoting a participant's well-being):

my use of empathy, congruence and UPR within the interviews and when co-constructing the data analysis, created a safe research environment. Research participation did not directly promote a participant's well-being, but the research encounter had the potential to be therapeutically beneficial; the study, indirectly, aimed to reduce stigma by giving voice to an otherwise marginalised group of people.

4) Non-maleficence (avoiding harm to a participant):

- *confidentiality of participant data in anonymising interview transcripts*
- *the use of codes/pseudonyms instead of actual names*
- *restricted use of personal data*

- *all data was retained in lockable filing cabinets or stored on a password-protected laptop and retained for audit purposes, as identified by the Research Ethics Committee.*

5) Justice (impartial treatment of participants and provision of adequate services):

- *contact details were provided in case of any complaints arising throughout the research process*
- *the emotional safety of the participants was maintained by the provision of free therapeutic support in the event of any distress being caused through participation.*

6) Self-respect (self-care for the researcher):

- *use of monthly clinical, academic and peer supervision*
- *reflexive journal, essay writing and note-keeping*
- *lone-working risk assessments.*

I now address my particular approach to the rôle of academic rigour within my study.

5.2 Addressing Methodological Rigour

5.2.1 Introduction

An obligation for qualitative research to demonstrate the integrity and rigour of its work (Angen, 2000) can, as Sandelowski (1993) suggests, be legitimately balanced with an artfulness associated with the discovery of meaning in a particular context. The theoretical perspective of the PCA acknowledges the autonomy of a participant, via the trust it places in his/her self-actualising tendency (Rogers, 1959). I aimed to: establish a trusting, empathic relationship with the participants; refused to accept the researcher's rôle of self as expert; maintained a sensitive adherence to the participants' own words without overt interpretation (coupled with the accuracy of

interview transcripts); and acknowledged the right of the participants to validate their data as part of the process of accurate symbolisation of their experience (see below).

I took additional practical steps such as: maintaining a reflexive journal; consistent essay writing and note-keeping; respecting participant confidentiality and anonymity; and giving voice to participants by using their *in vivo* quotes. I employed all these strategies to help contribute to the methodological rigour of my study (Sandelowski, 1993). I now outline how I considered and addressed the various criteria for academic rigour.

5.2.2 Theory pertaining to academic rigour

In qualitative research the criteria for measuring academic rigour (Willig, 2008) and "*the issue of quality criteria... is... not well resolved*" (Guba and Lincoln, 1994: 114). This may lead to idiosyncratic measurement criteria (Kahn, 1993), for example, Finlay (2006) who suggests her "5 C's" approach: clarity; credibility; contribution; communicative resonance; and caring.

For a study to be viewed as credible and authentic, Lincoln and Guba (1985) argued that certain criteria, also termed the trustworthiness or rigour of the research, must be evidenced. These criteria, manifested to varying degrees, are a blend of: credibility; dependability; confirmability/replicability; and transferability, (i.e. showing that findings have applicability in other contexts) all serving as implied benchmarks against which research is measured (Davies and Dodd, 2002). Guba and Lincoln (1989) added a further criterion of *authenticity* to their 1985 formulation.

Though such clear paradigmatic divisions may, currently, be being questioned and even regarded as unproductive, so that qualitative evaluation may be treated more pragmatically if linked with different paradigms and perspectives (Lub, 2015), there still remains, perhaps, a need for common validity criteria in qualitative research; I am remaining, therefore, with their original four-point criteria, (i.e. credibility; dependability; confirmability/replicability and transferability) which, historically, were regarded as the *quondam* "*gold standard*" of evaluation (Whittemore et al., 2001: 527).

Specifically, within psychotherapeutic research, Dallos and Vetere (2005) note a distinction between generalising (i.e. that findings are true to all or most situations) and transferability where the study may provide useful information derived from an aggregate understanding of its data, but which accepts those individual differences which constitute this aggregate (Lamiel, 1998).

In following a PCA methodology (see Chapter 6), which recognises the subjective uniqueness of experience, my study's findings were not expected to hold true (i.e. be generalisable) to all or other alcoholics outside of the study population but be believable to the participants taking part. I would argue that the PCA methodology (I.e. empathic listening, recording, analysing and offering reflexive feedback to the participants) as a means of enquiry can be transferred to different study populations, allowing that the findings generated will remain specific to that population. The absence of generalisablity was not a plea for permissiveness, as my study aimed at providing a seminal/organic descriptive re-presentation of its participants' subjective lived-experiences rather than one which was technical/mechanical and generalisable believing that, as Sandelowski (1993: 1) argues:

"... true-to-life and meaningful portraits, stories and landscapes of human experience constitute the best test of rigour in qualitative work."

5.2.3 Credibility

This determines whether the study's findings represent a credible conceptual interpretation of the data drawn from a participant's original narrative (Lincoln and Guba, 1985).

As the PCA advocates that as a person exists, temporally, in an evolving state of *becoming* and that the narrative-language s/he uses both reports his/her unique experiences, whilst providing the subjective framework which construes them (Rogers, 1951, 1959), objectively justifiable interpretations of a phenomenon are not possible (Rogers, 1961). Actions taken to achieve credibility included: the in-depth nature of data collection; submitting my findings to the critical analysis of the participants (see below); the use of the PCA in staying close to the participants' frame-of-reference; the use of their reported speech; monthly clinical and academic supervision; and regularly

presenting my on-going research to peer-evaluation (bio-medical and psychosocial) amongst my work colleagues.

5.2.4 Dependability

This relates to the researcher's need to account for the evolving context of the research and evidence an auditable process which documents the integrated processes of data collection and analysis and the theoretical decision-making process throughout the study (Lincoln and Guba, 1985). In addition to a reflexive diary/journal (extracts are provided in Appendix 14), monthly essays were submitted to the supervisory team for review which detailed the on-going process of my research and supported my changes within the methodological and theoretical design of the study. My descriptive re-presentations for each participant's narrative outlined the analytical process and evaluative decisions I made. (As an example, an extract of the analytical process of P1's transcript is provided in Appendix 12).

5.2.5 Confirmability/replicability

This describes the degree to which findings emerge from the participants' data and not the researcher's own bias. It relates to whether results could be confirmed or corroborated by others (Lincoln and Guba, 1985) and in particular the participants (McLeod, 2003). Member-checking and academic, clinical and peer supervision aided this process and, in the spirit of congruence, I have made explicit my reflexive bias throughout the study (see Chapter 2). I acknowledge that demonstrating confirmability, for this study is problematic (Hycner, 1985). At issue here was not, once the context and intention of the study was made known, whether another researcher looking at the same data differently would reach a divergent set of conclusions, but whether "*a reader, adopting the same viewpoint, as articulated by the researcher, can also see what the researcher saw, whether or not he (sic) agrees with it*" (Giorgi, 1975: 96).

5.2.6 Transferability

This refers to the extent that findings apply to wider contexts outside the study's immediate field (Lincoln and Guba, 1985) and whether they are grounded in experiences reflecting typical and atypical elements of the phenomenon (Sandelowski, 1986). My study did not seek to generalise its findings to other recovery contexts, but matched its participants against a highly focused set of research criteria.

However, the recovery stories of AA affiliates are primarily practical (Travis, 2009) and may mirror the exemplar narrative structure found in the autobiography of Bill Wilson (co-founder of AA) (AA, 1976: 1-16). This narrative style is emulated and reinforced within AA meetings (Hoffmann, 2003), as the principal means of communicating and sharing experience (Kassel and Wagner, 1993). Potentially, this meant that there could exist a similarity between my study's participants which could be benchmarked with the discourses of other AA affiliates who sought to affirm their acceptance of a commonly shared ideology (Thune. 1977).

5.3 Perceptions of rigour within this study

Conventional research criteria for rigour imply a rigid adherence to those qualities which characterise trustworthy qualitative research, as argued by Lincoln and Guba, (1985), rather than allowing for "*artfulness, versatility and sensitivity*" (Sandelowski, 1993:1) which are hallmarks of a PCA, but this does not make the PCA less rigorous. In seeking to capture the complexity and uniqueness of experience, the PCA applies an ideographic rather than a nomothetic research approach without aiming to generalise its findings (Dallos and Vetere, 2005). Instead, I deployed it in order to explore the lived-experience of a particular set of recovering alcoholics, recognising that human experiencing is both subjective and potentially limitless (Wray et al., 2007).

I also acknowledge that in different circumstances, with alternative questions, another researcher or participant group, the findings may have been very different (Lott, 1999). The descriptive analysis was member-checked and, though this process may be viewed, by some, as misplaced or untrustworthy (Giorgi, 2008), subjecting my writing to the critical appraisal of the participants aids, I suggest, the credibility of my findings

as being true and believable (Morse, 1994). The dependability of the study is evidence by the act of "*writing and re-writing (including revising and editing)"* (van Manen, 1997/2015: 131) and the submission of monthly essays summarising and offering to scrutiny the phenomenological approach I applied in data gathering, analysis and the evolving process of my reflexive approach to the study (Greenhalgh and Peacock, 2005).

5.4 The use of participant-validation

5.4.1 Introduction

Perhaps not inherent to a qualitative study of this kind, to offset the absence of transferability (Lincoln and Guba, 1985) its credibility i.e. that its findings could be legitimately viewed, by the participants, as believable and accurately describing their perceptions of the phenomenon (Trochim, 2006) in what McLeod (2003:95) terms "*experiential authenticity*", I placed great store in the corroboration of my re-presentations by the participants themselves. In what follows, theoretical implications for participant-validation are acknowledged, discussed and compared with *in vivo* examples taken from the participants' transcripts.

5.4.2 Theory pertaining to participant- validation

In the previous Chapter on Reflexivity (Chapter 2) I expressed my belief in the need for a collaborative approach to understanding the phenomenon of relapse. Serving as an intermediary between the participants' experiences and their own account of them (Steffen, 1997), I cannot help implicating myself in the research process (Nixon and Solowoniuk, 2008). I acknowledge that in changing the voice of a participant/narrator, I could, potentially, change the way in which his/her voice was heard (Polkinghorne, 1996). My study does not seek to make statements of objective fact, but actually presupposes an encounter with the phenomena which is already, in some way, a narrative-interpretation by the participants themselves (Bleicher, 1980).

To aid the reliability and rigour of research findings, Lincoln and Guba (1985) endorse the use of member-checking or participant-validation. Though not wishing to be accused of the "*quasi-militaristic zeal to neutralise bias and to defend our projects against threats to bias*" (Sandelowski, 1993: 1) each participant was invited, as a matter of personal choice and inclination, to review and critique the initial findings from their data, via a second, recorded and transcribed interview. This interview did not seek to elicit new information (see Request for Participation Letter, Appendix 2). One participant (P2) died before this could happen and one (P4), due to illness, could only provide a confirmatory letter. The remaining participants availed themselves of this opportunity.

It further aids the credibility of my findings as being true and believable (Morse, 1994), by demonstrating that my application of the PCA relative to empathic listening (and its core attributes) was faithfully and trustworthily applied *to the best of my ability* (Rogers, 1951, 1957). Any failure not to do so rests with me. Tangentially, member-checking also indicated the therapeutic benefit of the interview process for the participants (Zakrzewski and Hector, 2004), though this was unintentional (Chesler, 1991) but fortuitous:

"P5: ... I found being asked to do this, um, has enabled me to think a lot about myself, think a lot about my sobriety which I wouldn't have had an opportunity to have done in such depth and that in itself has been wonderful." (P5VT: 552-554)

As revealed in this quotation, participant-validation also stimulated the reflexivity of this participant (Casement, 1985/2008), which she found beneficial as an aid to her development of personal congruence (Rogers, 1961), by affording her the requisite time to engage with an extended process of reflexive thoughtfulness towards her experiences in the process of her recovery (Engward and Davis, 2015).

Notwithstanding, I acknowledge that validation by participants is not a *droit de seigneur* which, solely or automatically, confers reliability or validity to my study. The nature of my inquiry is ideographic and each participant's experiences are reported individually, as I sought, "*to gain rich descriptions of individual experiences or specific human phenomena"* (MacRenato, 1995: 134.) and is, therefore, not transferable. I have some reservations about ideography as I noted that, in some cases, an affiliation

with AA influenced, to varying degrees, the participants' expressive description of the phenomenon of alcoholism and relapse, particularly through the use of AA-derived metaphors and ideological constructs (Hammer et al., 2012).

Similarly, I attempted to avoid the manner, seemingly adopted by phenomenological research papers found within the literature search (Chapters 3), of comparing various life-narratives and in doing so appearing to discard unique, subjective life-stories, in order to reduce them to a series of universal and collegial themes (see Chapter 4). I agree with Sandelowski (1993) who states that an empirical attempt to validate experiences, described in one life-story compared with another, so as to arrive at a consistent set of transferable themes, "... *is completely alien to the concept of narrative truth and to the temporality, liminality and meaning-making function of stories*" (Sandelowski, 1993: 4).

An alternative school of phenomenology argues that research findings should be transferable (Nixon and Solowoniuk, 2008) and, therefore, fit into the experiences of another, whereby the audience views such themes as being both meaningful and applicable to their life-worlds, or that they could at least understand that such findings could be plausible in an imagined horizon (Moran and Mooney, 2002).

Though the process of social validation is important, it is a double-edged sword (Mishler, 1990). Social validation of my findings was also achieved through clinical, academic and peer review, as well as my extensive use of academic and clinical supervision but, ultimately, is a matter for the judgement of others.

There exists an historical and ambivalent debate within the ATRF as to the reliability of any form of self-report having both apologists (Sobell and Sobell, 1986) and polemicists (Kassel and Wagner, 1993), but being, pragmatically, viewed as the primary source of research data (Bergmark and Oscarsson, 1987), especially when confirmed by collateral verification (Connors and Maisto, 2003). Such views are drawn, however, from studies involving newly recovering alcoholics, whereas my participants were in sustained-recovery and so such conclusions may not be immediately valid, or be less serious (Dawson et al., 2007).

Member validation was formalised within my study as each participant, though under no obligation to do so, received a copy of his/her transcript and my working notes to

read. This served as an *aide memoire*, but I acknowledge that it may have been difficult to relive the moment-in-time captured by the transcript. I recognised that both the participants and I were stakeholders in the research process, albeit with different agendas, but this was not done simply to enhance the "truth" of my qualitative work. This study involved one researcher and six particular participants, at one point in time, from a defined geographical area of North West England; it cannot be, reliably, repeated.

I now illustrate some of the issues around member-checking with examples as they emerged within this study and compare them with research theory.

5.4.3 Theory of member-checking compared with its use in this research study

There are five principal areas of concern held by empirical researchers with regard to member-checking, which can be highlighted with specific examples as they occurred within the participant interviews. First, I concur that participants have an investment in their own experiences and may have immediately struggled to see my representation of their narratives:

"P1: When I first read it, er, I thought, "Have I said all that?" it was such a large amount of, um, data and then after re-reading it 4 or 5 times I realise now that is definitely me, er, from my perspective as I see myself." (P1VT: 8-10)

Secondly, if their motivation to participate in a research project was to justify or, potentially, defend their behaviour around relapse (Sandelowski, ibid), it could be materially different from my motivation to see their experiences through their eyes and so provide an understanding to the question, "Why relapse?"

"P1: What I had to do is, is legitimise that thinking with hindsight to think, I suppose if that was my end-game that was the thing that I needed to do to find sobriety today, to find out how bad it was or how bad it could be again, um...

R: But that kind of proved it to yourself?

P1: ... yeah, yeah. That isn't that isn't good thinking, it's the only way I can, can make it right in my head..." (P1: 228-233)

Thirdly, an interview could possibly evoke feelings or cognitions which a participant no-longer felt/thought and which may not have expressed his/her current state-of-being:

"P5: .... I'm saying all this in retrospect because I don't feel that way now..." (P5: 257-258)

Fourthly, their revisionist stories were time-bound, interpretive and moral acts (Lederman and Menegatos, 2011) which reviewed their past and current behaviours and the need, where appropriate, for reparation for intoxicated acts and not simply vehicles for the communication of information that were easily categorised (Sandelowski, ibid). They represented a participant's attempt to order, find meaning and live with events in his/her life at a particular moment:

R: ... um, (in your first interview) you talked about the fact that when you try and talk about this, or do talk about this with your family, your phrase was, "their eyes glaze over". It's not that they are not being supportive....

P6: Yeah. No, I did feel a bit guilty when I saw that but I'm sure that is that is what I said, (clears throat), I don't mean that they're not interested, I mean that they're just not understanding it..." (P6VT: 314-318)

Additionally, Sandelowski (ibid) also suggests that one danger of member-validation is that a participant may not remember (and so cannot check) the accuracy of his/her account:

"P5: ... I can't remember what was going on in my life at the moment in time but it wasn't because I was depressed,(pauses) ... I wanted to recapture something that I, that I had in mind, in my memory of my, of, of, of perhaps the good times when I had been drinking rather than the shit of drinking..." (P5: 239-242)

I tried to minimise these concerns occurring within the interviews, by the use of the PCA's techniques of reflection, paraphrasing and asking for clarification (Tolan, 2008). There was the additional problem in the difference between lay and scholarly

synthesis, as the latter has to adhere to different rules and purposes in representing data, which was not always readily intelligible. On reading his transcript and my working notes one participant stated:

"P6: ... I'm not going to pretend that I understood all of it, um, er, because I some of the language was, um, was not beyond me, it's just that I would have to have talked to somebody about what that meant, er, and you know before I could have understood it. But, um, I, I did find it, it was putting your finger on a lot of the things that, um, that I, er, felt and that I experienced at AA so it was, it was an interesting insight..." (P6VT: 14-18)

Though this problem was not applicable in every case:

"P5: I think what it did was it took me back to the interview with you and it flashed me straight back through my life and through the progression of the ups and downs of my life and into AA and into the absolute grinning from ear-to-ear of the confirmation of what AA is doing for me and does for me every day of my life." (P5VT: 11-14)

I recognise these concerns but disagree with the suggestion (e.g. Sandelowski, ibid) that member-checking becomes, in itself, a variable where there is dissension between any differing interpretations of the data. Mine was not an exercise in researcher interpretation with which a participant was simply asked to concur. I was trying to re-present the participants' words in order to describe, accurately yet sympathetically, their experiences as being idiosyncratic and separate exemplars of the relapse phenomenon. Consequently, where a participant signified that I was misrepresenting his/her data, his/her assessment was used:

"R: ...It's almost as if an alcoholic speaks for themselves, but because they're alcoholic and they share a condition with other people it's almost as one can speak for all.

(Participant's partner enters room, whistling)

P5: Er, I don't think so.

R: Okay.

(Door slams)

P5: I don't think so. Yeah.

(Whistling from partner)

R: Alright. Okay, I'll scrap that one." (P5VT: 517-525)

A sixth and final area of concern was that of participant deference (Rennie, 1994) and the possibility that participants would engage with the validating process, if only to meet the expectations and needs of the researcher. This is similar to the proposition of Nordfjærn et al., (2010) who suggest that only highly-motivated people take part in addiction-research which, thereby, conditions findings. The possibility that in different circumstances and with a different researcher, the narratives of the participants could have been materially different does exist (Hycner, 1985; Lott, 1999). One participant, P6, stated openly that he could not comment on craving because he claimed, "*I'm not an expert*" (P6VT: 305). More than the others, he was aware of the difference between alcoholics and non-alcoholics:

"P6: ... I am an alcoholic, and I am not saying that lightly, that, that is a recognition that I am different now... "(P6VT: 170-171)

I was not consciously aware that the participants were being deliberately deferential, except by the fact that they were forgiving and tolerant of my mistakes when these occurred (Rennie, 1994; 1998). The PCA aims to flatten the power differential within any relationship (Rogers, 1978), so that a research-participant did not have to be obsequious. Although participants allowed me to direct their narrative:

"P1: er, um, you know as I say Chris...my Christian faith and Jesus my Lord does play a lot in my life um and, er, I think part of that helps me to be spiritually fit as well...

R: Yeah. So just going back to the, well the purpose of this research is to try and understand relapse... "(P1: 148-151)

they were sufficiently emboldened to refute some of my statements and engaged with the process at a level of honesty and self-disclosure, which seemed to be unreflective

of deference, but did indicate a willingness to participate fully. They also stated, in various ways and with apparent genuine sincerity, how they had benefited personally from the whole experience:

"P3: I have found it fascinating, I have found the ability to read through and to spend time looking at what I've said and making sense of what I've said and and getting feedback on what I've said, I've found fascinating and it really feels that it's deepened an understanding of what's brought me to where I am today. It's been a joy to read." (P3VT: 460-463)

In fine, the PCA places implicit trust in a participant's autonomy that s/he will narrate his/her life story with honesty. It also acknowledges, that even though every attempt may be made to see and describe the experiences of a person "as if" one is trying to see the world through his/her eyes and from his/her frame of reference, that "as if" quality means that even the most sincere attempt at representing his/her experiences fails in verisimilitude and is, at best, a well-intentioned simulacrum (Rogers, 1959).

5.5 Chapter Summary

Having secured ethical approval, the safeguarding of the participants/researcher was enhanced by applying the ethical principles of the BACP to permeate the study as a whole. Mindful of this consideration, ethical issues were reviewed at monthly academic and clinical supervision.

Ethical considerations are pervasive throughout all aspects of a research project and require judgements to be made between decisions which, at the very least, should do no harm (Dallos and Vetere, 2005). Ethical considerations also inform the academic rigour of a study (Timulak, 2005), although it is impossible to design ethically neutral studies (McLeod, 2003). To resolve the dilemma between volition and autonomy, I sought to explain the ramifications of involvement with this study in such a way that participants would reach an informed consent, feeling themselves to be competent, having been provided with sufficient information by me, so that their participation was wholly voluntary (McLeod, 2003).

In using the PCA approach I acknowledge that I was running the risk of ignoring some aspects of academic rigour (credibility and transferability) which have otherwise been deemed essential in demonstrating the quality of research (Sandelowski, 1993). Though an aim of my study was not to generalise its findings to other contexts, the question of credibility was augmented by my use of member-checking which, in itself, is an ethical duty supporting a participants' right to know how his/her data is being used (Lincoln and Guba, 1985).

Having outlined the ethical considerations involved in the use of the PCA, Chapter 6 explains my choice of methodology, its philosophical underpinnings and its view of the rôle of researcher.

6.0 Chapter Six: The PCA as the choice of methodology

I now detail my reasons for choosing the PCA as my study's methodology; provide a brief review of alternative approaches, not fully covered in Chapters 3 and 4; and outline the beliefs underpinning the PCA, as it applies to research. I describe the rôle of the PCA researcher and address some practical limitations of its use.

6.1 Introduction

Having refined my research question in the light of my literature review (Petticrew and Roberts, 2006) and as a person-centred clinician/researcher, I sought to employ a methodology that would, faithfully, capture the intrinsically personal and unique voices of the participants. I was not proposing to create any over-arching hypothesis of the phenomenon of alcoholism/relapse; nor identify generalist themes applicable outside the study's population; nor reduce data to arrive at what could be interpreted as the "essence" of the phenomenon.

Instead, I aimed to provide a seminal/organic descriptive re-presentation or account of the participants' lived-experiences, rather than one which was technical/mechanical, being overlaid with external interpretation (Roth and Fonagy, 1996). As Mearns and McLeod (1984: 388) argue, "*the primary objective of the person-centred researcher is to give an account of the frames of reference or perspectives of research participants.*"

Consequently, I proposed to view the phenomenon through the eyes of each participant, but where my personal insights would retain what Rogers termed an "*as if*" quality (Rogers, 1959: 211), only ever being an approximation or simulacrum of what that experience could be. This is unlike the philosophical, relational phenomenological approach advocated, by Merleau-Ponty (1962/2002: 138) which, in a therapeutic or research application, would be hard to justify, as there could be no "*reciprocal insertion and intertwining of one in the other*" as he suggests. Within the PCA, an empathic response is not understood to mean being lost or subsumed within the state of another (Shlien, 2001) because, even within a dialogic/dyadic collaboration, which has been co-created by both participant and researcher (Merry,

2004), there always exists an "*as if*" quality separating the two collaborators. In portraying the perceptions of the participants, particular attention would be paid to their use of eidetic metaphor, being freighted with meaning and personal implications, unique to an individual (Tudor and Worrall, 2006) which, I believe, could open a window into their perceptual field (Worsley, 2002).

Originally, standing outside traditional mainstream research methodologies I, erroneously, believed that the PCA would not be estimated as a viable approach for a PhD research study and so considered a *bricolage* or pluralistic methodology, even though this would have necessitated harmonising sometimes contradictory epistemologies (of qualitative or quantitative research) which might have given my methodological approach an *ad hoc* flavour. However, in the context of my study's aim (to elicit a compelling ideographic description of experiences surrounding relapse) and as a clinician trusting in the actualising tendency of the participants, I believed that this aim could be best achieved by deploying the PCA. Furthermore, I did not believe that a pluralistic approach would dovetail with my own academic skill-set or therapeutic background. For example, I am trained not in the statistical analysis of data, but in the interpersonal and relational encounter between people. Though, as the researcher, I provided my study with its impetus, the intent of the PCA is to be non-directive so that any choice of an additional method would need to be mutually supportive and complimentary to that primary intent. A single methodological approach appeared "*easier*" to manage (McLeod, 2011: 191) and allowed for an observable and congruent thread to run throughout the study from the formulation of the research question within a PCA setting; through both data collection and analysis; and where any findings would, ultimately, return to a PCA milieu and thereby close that gestalt.

Ultimately, therefore, my choice of the PCA was concordant with my clinical practice (from which the research question had originated) and congruently reflected my belief in the self-reflexive agency and actualising tendency of an individual (see below). I now give consideration to the remaining methodologies suggested for psychotherapeutic research (heuristic, ethnographic, discourse/narrative analysis and case study) and describe why I felt these unsuitable in answering my research question.

6.2 Theory pertaining to the choice of methodology

Research seeking to "*generate data which give an authentic insight into people's experiences*" suggests a qualitative paradigm (Silverman, 2004: 91). Within my literature search/review (Chapters 3 and 4) I discerned a common thread, implying that most methodologies claimed to see the world from their participants' viewpoint, understanding their reality from their perspective and within their natural environment or social context (Brooks, 1994). This orientation may have been person-centric (in as much as it dealt with people) but, nevertheless, utilised lived-experience in the service of validating pre-emptive, nomothetic solutions to relapse (e.g. Gerwe, 2000) or recovery from alcoholism (Lakeman, 2013) and where the presentation of findings appeared weighted towards authenticating researcher-interpreted conclusions.

Hein and Austin (2001) state that there is no single correct way to conduct phenomenological research; the methods employed depend on: the purpose of the study; the investigators skills and talents; the nature of the research question; and the data to be collected. West (2013) further posits that the clinical orientation of the researcher has a pragmatic influence on his/her choice of methodology and, on reflection, I believed that the relapse phenomenon was, potentially, better understood by being person-*centred* and listening to diverse experiences of relapse, integrated into a process of recovery *in alcoholism* (Lakeman, 2013) as they were expressed from their frame-of-reference (see Chapter 3). My study's participants were to be drawn from AA which views alcoholics, living in sustained-recovery, through a phenomenologically constructed lens (Robertson, 1987), but about which the ATRF had scant knowledge (Laudet et al., 2014).

The ATRF's operationalisation of grounded theory and IPA was explored in Chapters 3 and 4. Though not hostile to these theories to answer my research question, I was not aiming to produce any substantive theory about relapse and whilst IPA studies, within my review, may prize lived-experience as part of their approach, they appeared to dilute the uniqueness of participant experience in favour of providing generalised/abstract themes leading to generic conclusions. These were predominantly researcher-determined and deemed, vicariously, transferrable to other situations.

Less reviewed within my literature search, were heuristic, ethnographic, narrative/discourse analysis and case-studies which, according to Creswell (2007) and McLeod (2001, 2011), are the other most commonly employed research methodologies for psychotherapy and healthcare research, particularly when seeking insights into the social reality of people living with particular conditions (Biggerstaff and Thompson, 2008). A brief overview of these qualitative methodologies (see below) indicates why I felt they were not wholly appropriate to my research question and why my clinical orientation (West, 2013) steered me towards a more participatory PCA method of enquiry.

In short, there appeared to be no single methodology/theory, either used by the ATRF in which this study was grounded or suggested for psychotherapeutic research generally, which provided an unequivocally clear window into subjectivity/human experience (Kvale, 1992, 2000). My literature search/review had suggested that the variety and uniqueness of human experiencing was indeterminate and ambiguous (Wertz, 2005) so that it appeared potentially limitless (Wray et al., 2007). Arriving at the *essence* of the phenomenon (Husserl, 1927) might not be either achievable or necessary (Wray et al., 2007). But, in according more prominence to the equality of the inter-subjective connection and dynamics between participant and researcher (than is usually found within traditional methodologies) I acknowledged that in different circumstances, with alternative questions/methodologies, another researcher or participant-grouping (Lott, 1999), findings may have been substantially different (Hycner, 1985).

6.3 Heuristic

An heuristic, or auto-ethnographic approach (Richardson and St. Pierre, 2008) could provide a restricted glimpse into one person's experiencing (Moustakas, 1990). I was not intending to suspend or bracket my personal and clinical experiences which shaped my understanding of relapse and which, hopefully, could help establish some rapport with my participants in seeing the world through their eyes (Charmaz, 2006).

A distinguishing feature of the addictive process is an alcoholic's "keeping back" or his/her "denial" of experience (Dufour, 1999) which, in the context of an interview and

as a epiphenomenon of the process of relapse itself, may perhaps be significant (Hycner, 1985) but which the heuristic element of my experience could be useful in identifying. As a critical observer of people, my clinical experiences could bring an immediacy of participation into something of the shared-world of my participants (Prus, 1996). However, I was not seeking to understand relapse from my own internal frame-of-reference (Moustakas, 1990) but that of my participants.

6.4 Ethnographic

As AA affiliates, participants would be drawn from a defined, stigmatised (Room, 2005) and ethnographic group (Schomerus et al., 2010), possessing identifiable shared-values, beliefs, symbolic language, objectives and behaviours, (AA, 1976). AA has discernible working patterns which warrant study and fulfilled the criteria for this methodology (Creswell, 1998; 2007). Additionally, ethnographic research has been used to clarify epidemiological understanding of substance-abuse (Stahler and Cohen, 2000). For example, Biernacki (1986) deployed ethnography to identify why some heroin-addicts sought treatment and others recovered without it. The acquisition of heroin-use and a recovery processes also allowed for his study to follow the phenomenon's linear temporal process of development.

I could apply a critical, rather than a realistic, ethnographical approach in the context of a constructionist study of both alcoholics and their views of relapse as a phenomenon within their cultural life (Alasuutari, 1996). Interview questions would need to reflect a symbolic interactionist emphasis, to learn about the participants' views, elicit their definitions of terms and try to tap into their assumptions, implicit meanings, metaphorical allusions and tacit understanding of experienced events and actions (Charmaz, 2006). I have already indicated my regret at using semi-structured interview questions (see Introduction).

However, I was not seeking to understand the mechanics of AA's group processes, nor how specific AA interventions worked. Nor was I championing any social causes, nor did I possess any theories as to what might be discovered. Field-work would be restricted to open-AA meetings and beyond our initial, brief contact (to explain my research) and the subsequent primary and secondary interviews, full data-collection

would not emerge from my cultural immersion within any specific group. Contact would also be limited due to the need for participant confidentiality (McLeod, 2011) as, implicit in the name *Alcoholics Anonymous,* is the protection of a person and his/her desire to retain anonymity, usually to avoid stigma (Williamson, 2012; van Boekel et al., 2013). Access to participants, in the end, proved problematic, which would have hampered the study had this methodology been chosen (see Chapter 8).

6.5 Discourse/Narrative analysis

My study involved recording and transcribing stories of lived-experience, made incarnate in narrative discourses (Crotty, 1998). Though some phenomenological approaches consider language inadequate for expressing experience (e.g. van Manen, 1997/2015), these autobiographical stories are the accounts/organising principles, of what happens to participants when experiencing recovery/relapse. Storytelling, complete with the richness of expressive phonology (Labov, 1972); metaphor (Lakoff and Johnson, 1980); and gradient symbolism (Rösch, 2004), is AA's basic (human) strategy for its members to explain, explore and come to terms with time, process and change, in relation to alcoholism/recovery (Nelson and Fivush, 2004).

AA affiliates share an idiosyncratic meta-language which constructs an understanding of what it means to be *alcoholic* (Sandoz, 2009) and, using metaphorical terminology, (e.g. powerlessness, Higher Power, spiritual-awakening etc.,) expresses the phenomenon of *alcoholism* (Marlatt and Fromme, 1987). This language mediates and constructs, perhaps, not only their phenomenological understanding of alcoholism, but also defines their social rôle and behaviour within society (Chandler, 2002). A plethora of eidetic metaphors also illuminates their narrative structures (Alasuutari, 1996). Given the extensive literature on AA narratives' use and significance of metaphor (e.g. O'Halloran, 2006; Matheson and McCollum, 2008), I anticipated that such linguistic devices would offer intrinsically personal and ideographic insights into the relapse phenomenon.

Narrative research was a methodological option but, of the variants, discourse rather than narrative analysis could have illuminated (through the shared, mutually agreed use of language rather than, perhaps, eidetic metaphor) how alcoholics are forced to

exist broadly in relation to the historically-based, dominant ideologies that structure both societal attitudes towards them and their own response(s). This would focus on the over-arching construct of how alcoholics viewed themselves as being "different" (Habermas, 1971; Foucault, 1978) and how they negotiated their personal and group-identity *vis à vis* societal norms (Starks and Trinidad, 2007).

But my study was not seeking to explore how participants created meaning through their use of commonly-used or group-sensitive language, as their notions of a self, singly or collectively, may not necessarily have been prototypical of any one position. Nor did I seek to address a wider conceptualisation of the phenomenon of relapse. The reality of inner-experiencing was not easily reconciled with discourse analysis, which takes a more social/relational approach to understanding human experience (Powers 2007). On the other hand, narrative analysis could examine the life-stories of participants, rather than the process of their story telling, but I was seeking to represent the unique categories of experience within their narratives, rather than disassembling the coherence and structure of a narrative as a unitary vehicle for communicating meaning (McLeod, 2011).

Narrative analysis could form a highly interpretative and evaluative commentary, moral in overtone perhaps, detailing a breach (caused through alcoholism/relapse) between the self (the ideal and the real) and self and society (Riessman, 1993; 2008). However, the narrative story itself was not under investigation nor, with a small sample size, was it expected that its conclusions would be generalisable (Ellis and Bochner, 2000). What I hoped to explore was not *the way* in which people told stories, acknowledging that as active reflexive agents, these stories might be told differently under different circumstances (Lott, 1999), but the underlying aspects of their understanding of the phenomenon of relapse *as*, rather than *how*, they expressed it.

The collaborative nature of narrative research is, nevertheless, in keeping with my belief in a dialogic construction of reality (Clandinin and Connelly, 2000) and acknowledges that narrative (as a paradigm) is a rhetorical expression of the holistic self, being a synthesis of *logos* (the reliable and factual) and *mythos* (value-judgements, metaphor and the un-verifiable) (Fisher, 1985).

6.6 Case Study

Pragmatically, this was an attractive methodology as each participant's discourse formed a case study within itself (Smith et al., 2009). Participant recruitment relied on purposive sampling (i.e. criteria for participant-inclusion relating to my research question) and whoever was available and matched to those selection criteria. Herein, lay the problem. I was not trying to find a lone participant who was an exemplar or was proto-typical of the relapse phenomenon. Instead, I sought to explore the complexity of an experience across a small, heterogeneous group of people with specific attributes, but not to over-generalise their experiences as being, vicariously, applicable to a wider grouping or within the group itself (Gomm et al., 2000). This acknowledged that each life-experience was unique and, through comparison with others, could elicit the diversity of the relapse/recovery experience.

Without involving a small group of participants, there would be no way of knowing how the selective and biased experiences of one participant (Spinelli, 1997) applied in other therapy-researcher/client pairings; the variance between how one person expressed his/her experiences as "alcoholic" versus another; or whether, in fact, what participants said was contingent upon the situation of the interview in which they found themselves (Potter and Wetherell, 1987). I was not attempting to test a theory, but rather develop or build an exploratory, co-constructed description of the phenomenon under investigation and so the sample-size, of one or two participants, restricted comparison.

6.7 My choice of the PCA as a research methodology

Originally, I had believed that I could, authentically, draw on elements from each of the above methodologies, to create a qualitative, phenomenological *bricolage* methodology. Such an approach has empirical validity (Brannen, 1992; McLeod, 2001, 2011; West, 2013) allowing for the use of different techniques to gain access to different facets of the same phenomenon (Olsen, 2004). But, unlike a single methodological approach, this would require me to confront additional tensions between different theoretical perspectives and the relationship between data-sets

produced by different methods (McLeod, 2011). On reflection, I felt this to be unnecessarily cumbersome.

Additionally, my unease with the imbalance of power between the researcher/participant (to which I refer in Chapter 2) centred on the axiom that the researcher is held to be the dominant expert. To overcome this objection, I sought a participatory rather than interventionist methodology (Halling, 2008). Furthermore, I was not seeking merely to *give voice* to the participants (Larkin and Griffiths, 2002) but was attempting to gain access to, and understand accurately, the phenomenological, existential field of a person (Worsley, 2002). My aim was to provide an account, in his/her own words, of his/her internal frame-of-reference and the unique perspective of his/her perception and phenomenological experiences of relapse (Mearns and McLeod, 1984) irrespective of how this might tessellate with the experiences of others.

This marks the difference, I suggest, between research which is person-centric and that which is person-centred as posited by Rogers (1951; 1959). This would include how a participant, subjectively, made sense of that experience to formulate a construct or constructs of self, assimilating it within the process of his/her self-actualisation towards recovery. These experiences could be compared with those of others, which could highlight similarities or differences but, as each description of experience was unique, they would not be used to infer any generalised principles.

I chose, therefore, to deploy the Rogerian person-centred approach (PCA), in which I am trained, a methodology drawing on the writings of Carl Rogers (1942, 1951, 1957, 1961, etc.) which informs practice in fields other than therapy, particularly research into areas of health-care and well-being (Embleton Tudor et al., 2004)., e.g. Coghlan, (1993); Joseph, (2004); Murphy et al., (2013); Clarke, (2014). As previously stated (see Chapter 2), the connection between the PCA and the phenomenological paradigm is found in two key statements by Rogers (1951: 483-484):

"Every individual exists in a continually changing world of experience of which s/he is the centre."

"The organism reacts to the field as it is experienced and perceived. This perceptual field is for the individual, "reality"".

Being phenomenological the PCA provides not only a methodological and theoretical framework for my research, but also its research techniques based on an epistemology of empathy, unconditional positive regard and congruence by which my study could be conducted (Mearns and Thorne, 1984). To be applied congruently, this methodology would be extended through data-gathering to the analytical process, which is viewed as being conducted systematically (Berkowitz, 1997) and an unfolding iterative reflection on a narrative in a similar process to that undertaken within PCA treatment (Reid, 2010). To maintain, within research, the Rogerian tradition of prizing the uniqueness of an individual (Barrett-Leonard, 2003), the five basic features of PCA research (Mearns and McLeod, 1984) maintain that:

1) participants are treated as equals, or collaborators in the research process

2) the goal of research is to explore and understand, empathically and accurately, the subjective frame-of-reference of another (this reflects the phenomenological nature of the PCA)

3) research is a process and not an activity focused on outcome

4) the researcher maintains a congruent stance throughout the entire research process

5) participants' experiences are accepted in a non-judgemental manner.

My methodological approach, therefore, would be to listen and attend, empathically, to the narratives of recovering-alcoholics, faithfully recording their experiences of alcoholism/relapse in such a manner as to re-present those experiences without an overlay of clinical expertise. Using the phenomenological skills or methodological techniques of the PCA, i.e. empathy, UPR and congruence (Tolan, 2008) to foster an attitude of openness and readiness to hear (Buber, 1958/2000), I sought to express each participant's narrative, which is in itself highly selective, biased, capricious and subject to change over time (Spinelli, 1997), but where any description of his/her experiences was to be recognised as tentative (Rogers, 1951). Consequently, my focus was less towards interpretation, beyond that inherent in all human interacting (Worsley, 2002) and more towards empathic listening, congruently responding to what was said and, where necessary, seeking clarification (Thorne, 2003).

The PCA holds that interpretation is a process more properly found "*within the experience of the participant, rather than in the intellect of the researcher*" (Rogers,

1951: 224). Therefore, the power dynamic between interviewer and participant was to be equalised (Mearns and Thorne, 1995); the meta-communication between both parties implied that this enterprise was an alliance, with each being expert in his/her own field (Rennie, 1998); and where a meeting of two persons, at a specific time and place, learning from the other (Casement, 1985/2008), would co-construct a congruent, tentative description of experiences of alcoholism/relapse (Bozarth, 1998). It would also involve the reflexive process of both researcher and participant (Mearns and Thorne, 2005) especially as my mediation between abstraction and experience would be subject to the validation by the participants themselves (Sandelowski, 1993).

I now identify the PCA's key elements applicable to research and why I believe this methodology is suitable for my research question.

Briefly, the PCA holds that a person (or organism) has a tendency to self-actualise (which is inherently trustworthy) as s/he moves towards a position of integrated emotional, psychological and mental well-being. The researcher, using the core conditions of the PCA, helps create: an environment which allows this process to flourish; a participant to symbolise his/her experiences more accurately; whereby the researcher is enabled to perceive a participant's frame-of-reference. The researcher does not intuit meaning but, instead, helps a participant to describe, with increasing precision, his/her understanding of experience.

I will now address the underpinnings of the PCA, beginning with its theoretical background; its view of an individual as an organismic entity; the theory of the tendency to self-actualise; the primacy of a person's frame-of-reference; the rôle of the researcher in applying the PCA's core conditions and helping a participant, accurately, symbolise his/her experiences; and, finally, potential limitations of this methodology.

6.8 Theoretical background of the PCA

First, the PCA acknowledges that its "*foundation blocks*" (Rogers, 1979: 98) or philosophical beliefs are not empirically verifiable, (Brodley, 1999). Believing that, if theory (which is often fallible and evolving) is to be profitable, it must "*follow*

experience, not precede it" (Rogers, 1951: 440). The PCA is, therefore, a clinical and functional (rather than abstract or academic) philosophy or subjective *way-of-being* (Rogers, 1980). Philosophy here means the underlying principles *from which* and *on which* a person builds his/her idiosyncratic lifestyle and chooses how to behave and which become outwardly manifest in his/her thinking and behaviour and for which s/he is responsible (Rogers, 1961).

In other words, the PCA focuses on the *process* of being and functioning as a person and where all outcomes or meanings follow from that person's increased capacity to experience, fully, aspects of self which have been ignored, distorted or denied to the self as being unacceptable in some way (Tudor and Worrall, 2006). Being subjectively phenomenological it recognises, as inviolable, the subjectivity of individual experience (Rogers, 1961) and does not imply that a participant's personal philosophy of life must conform to an objective "reality", social consensus or essence, which the PCA eschews, in fact, as being a "*luxury*" or "*myth*" (Rogers, 1980: 104).

Central to the PCA's understanding is that it is not the active rôle of the researcher/clinician to make sense of experiencing. Instead, s/he helps create a physical/temporal space conducive for a person to explore, challenge, clarify and reflect upon his/her descriptions of experience, in the presence of another (Tudor and Worrall, 2006). The quality of this dyadic relationship (co-created between two individuals) and a participant's perceived or subceived experience of being accepted and listened to (Bozarth, 1984), enables him/her to work back, inferentially and compare what s/he has said with his/her current, personal philosophy of life and ascertain whether his/her statements have been accurately expressed, thereby promoting a greater congruence between experience and self-awareness (Rogers, 1951).

A participant does not need to infantilise his/her capacity for self-reflection or correspondingly idealise the researcher as being necessary to his/her well-being; research is not considered to be therapeutic, though a person's perceived experiences of being prized within a dyadic relationship (Robinson, 2000) may, unintentionally, precipitate therapeutic change (Chesler, 1991). For example:

"P3: I have found it fascinating, I have found the ability to read through and to spend time looking at what I've said and making sense of what I've said and and getting

feedback on what I've said, I've found fascinating and it really feels that it's deepened an understanding of what's brought me to where I am today." (P3VT: 460-463)

The idea that a person has such corrective capabilities is underpinned by the PCA's innate belief/trust in the unforced tendency of human beings (as living organisms) to actualise their potential, given a conducive environment, but forsakes the mystique and other "*powerful behaviours*" of therapists/researchers' expertise in interpreting his/her discourse (Tudor and Worrall, 2006: 3).

6.9 A person as an organismic entity

Secondly, the PCA treats a person as being a functioning human *organism* and not merely a collection of constituent parts. Rogers (1959: 200) who equated the terms "*self*", "*self-concept*" and "*self-structure"*, suggested that the self, though operationalised by diagnostic labels is, nonetheless, a "*fluid and changing gestalt*". However, focusing solely on particular aspects or themes of experience ignores the totality of human experiencing. Whereas the ATRF researches addiction by examining specific effects on different aspects of the self: e.g. self-identity (Kellogg, 1993); self-efficacy (Marlatt and Gordon, 1985); the physical/material-self (Castonguay and Beutler, 2006); the social/spiritual-self (Bowden, 1998); the biological (Koob, 2009) or genetic-self (Prescott, 2002), the PCA views the human organism holistically, being the integration of the entirety of a person (bio-medical, psychological, spiritual, emotional, etc.,) which is the source of subjective experience, subjectively evaluated and which informs the personality:

"... the client discovers that he (sic) can be his experience with all of its variety and surface contradiction; that he can formulate himself out of his experience, instead of trying to impose a formulation of self upon his experiences, denying to awareness those elements which do not fit." (Rogers, 1951: 80)

In short, anything which is described (or diagnosed) psychiatrically via its constituent parts and not clearly *organically*, is a form of alienation inimical to a sense of personhood (Rogers, 1951). In sum, the PCA views the living organism (indeed any organism) not as a metaphor (to explain experience) or as a theoretical construct (e.g.

the self), but as a "*real given entity*" (Spielhofer, 2003: 80), which is in a perpetual state of flux and evolution (Damasio, 1994/2006). Any organism is not to be understood outside of its environment, in which it tries to become adequate; this is its inherent tendency. Tudor and Worrall (2006: 87) suggest that it is more useful to say that "*the organism is a tendency to actualise*" making it functionally synonymous with life (Rogers, 1978).

6.10 The organismic tendency to self-actualise

Thirdly, the PCA posits that, as an organismic whole, a person is subject to both a formative and an actualising-tendency in its striving to become fully-functioning. Fully-functioning is a nebulous phrase, perhaps, but attempts to describe a person who is living in a state of increasing harmony with what Rogers terms the "*is-ness*" of self (Rogers, 1967: 181). The formative tendency is a natural (i.e. of nature), universal and evolutionary concept inherent to all living organisms, which leads towards form and order within the universe (Rogers, 1979). Whether this includes notions of the Transcendent is a matter of personal conviction (Mearns and Thorne, 2005). Concomitantly, the actualising-tendency, "*is the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism*" (Rogers, 1959: 196).

Part (or parts) of the process (of actualisation) may be consciously appreciated and expressed (symbolised) by a person as being an aspect/aspects of a person's self-concept/self-construct. Actualisation can be organismic (i.e. biological, genetic and autonomic) which dovetails with the ATRF's bio-medical research but, similarly, the organism/person actualises his/her "self" (which is a conceptual element within the organism and so closer to the ATRF's psychosocial research). This is the organism's "*awareness of being and functioning*" within the passage of time (Rogers, 1951: 47). Mearns (1999: 130) refers to this as "*configurations of self*" which are fluid and constantly changing, in the light of new experiences and a sense of differential from others.

Conversely, whilst the capacity for rational thought, self-awareness or reflective consciousness is the salient human channel of the actualising-tendency (Brodley,

1999), problems occur when that channel of the actualising process goes awry (Rogers, 1951). Discrepancies may arise with an organism's actual experiences which are either unrecognised or denied to the self, by not being accurately symbolised or distorted in a selective fashion and in such a way as to be incongruent with the self-picture (Rogers 1959). It is here that distress can occur.

For example, any behaviour (e.g. a dangerous use of alcohol) could be viewed as being not only the best a person could do in any given moment (given his/her perception of his/her inner and outer environment), but may also serve as a protective, self-preserving act orientated towards the organism's need to survive (Tobin, 1991). Dufour (1999) and indeed AA (1976) would classify this as an act of wanton denial. The PCA, however, would recognise this (empathically) as being a valid part of the evolving process of self-actualisation (unconditional positive regard) or as Rogers (1961) terms it "becoming," but which would be reflected back to a participant (congruence) so that each participant's own internal evaluative process could re-assess this or not (Schmid, 2001).

In PCA terms, what is important is whether a person is open to experience, is trusting of his/her organismic internal locus-of-evaluation and is willing to be in the process of change. Rogers (1961) refers to this process as one where a person gets behind the mask or rôles which s/he assumes in life and so discovers unknown elements of "self", or "Eureka!" moments of integrating experiences, which may have been hovering at the edge of the conscious awareness (Mearns and Thorne, 2005).

6.11 <u>The primacy of a person's internal frame-of-reference</u>

Consequently, if an organism/person, consciously or otherwise, has an organismic tendency (which is neither moral nor immoral) to respond to his/her environment by a process of actualisation which, hopefully, maintains or enhances the organism/person (Rogers, 1959), then it follows that in reacting to that environment "*as it is experienced and perceived, this perceptual field is, for the individual, "reality""* (Rogers, 1951: 484). In other words, the researcher does not have to discern meaning as there can be no meaning, applied to any experience, other than that which is discerned from a person's own frame-of-reference, which the researcher attempts to perceive (Rogers,

1959). In short, the purpose of a PCA research-encounter is to listen empathically to another and to perceive, with accuracy, the "*internal frame of reference of the other...as if one were the other person, but without ever losing the "as if" condition*" (Rogers 1959: 2010). The "*as if*" quality recognises that access can only ever be partial (Shlien, 2001).

6.12 The rôle of the researcher and the use of the core conditions

Therefore, the researcher's rôle is not to dominate the study, but to try and view the perception of the phenomenon through the eyes of each participant (Rogers, 1959). S/he exemplifies this by employing the core conditions of the PCA (empathy, UPR and congruence) which form an "*integral whole, none separable from the others*" (Gaylin, 2002: 340) but, in research-terms, are not used to establish psychological contact (prior to therapeutic change) but develop a relationship which is respectful and ethical, primarily paying attention to what a participant says, so that each feels sufficiently safe/comfortable to speak about him/herself.

It is assumed that participants are in the process of evolving towards a position of functioning, successfully, within their sustained-recovery. My participant criteria attempted to eliminate the comorbidity of serious negative-affect, allowing for temporary feelings of incongruence (e.g. low mood) which is, from time-to-time, a "universal symptom" of the human condition (Van Kalmthout and Pelgrim, 1990).

Empathic understanding is to perceive the internal frame-of-reference of another (his/her emotions and descriptive expressions) with accuracy. This combines with the researcher's technique of *reflective listening* which attempts to understand a participant's perceptual map or how s/he perceives and makes sense of his/her world, rather than who s/he is in any fundamental or apparently objective way (Tudor and Worrall, 2006).

Unconditional positive regard (UPR) is the researcher's willingness to be non-directive because s/he trusts implicitly in a participant's integrity to interpret and re-order his/her own experience, in other words, his/her organismic tendency to self-actualise (Schmid, 2001).

Congruence describes the researcher's personal consistency between his/her experience and self-awareness, i.e. his/her own capacity to be real and genuine (Rogers, 1961). It relates to how s/he implicitly communicates this (verbally and non-verbally) to a participant (Haugh, 2001) to convey the fact that, at no time within the research process, does s/he feel that s/he is the sole expert, but is, authentically, in the presence of one who is "*expert by experience*" (Slade et al, 2012: 353). Nor, as a researcher, is s/he engaged in a process of effecting therapeutic change, but that psychological readjustment (i.e. the enhanced matching of experience with awareness) may be an unintended outcome of a researcher/participant encounter (Chesler, 1991). Conversely, it also acknowledges and allows for inconsistencies (incongruence), as perceived by a participant, which are revealed in his/her narrative, but which may not necessarily be pathological nor detrimentally affect his/her functioning or the integrity of his/her self-concept (Brazier, 1995).

6.13 The researcher's rôle in the symbolising of experience

Rogers (1951, 1959) argued that as perception is reality, so language does not simply report experience, but provides the defining framework for it; i.e. language construes a person's experience by describing his/her perceptions of that reality. But, as a participant's language and story may often change this, in time, may alter the description of his/her experiences. Unlike the ATRF, (e.g. Marlatt and Gordon, 1985) the PCA does not view a participant's narrative with ambivalence or mistrust. It accepts, at face value, the propositions as stated by a participant but, concomitantly, enables a narrator (who experiences its core conditions as they are provided by the researcher) to explore and question the accuracy, validity, completeness and usefulness of the words s/he has used (Rogers, 1951).

Secondly, language socialises a person into a way of thinking about him/herself which means that professional, diagnostic classifications which impose delineated, prescriptive ways of being on a person, are antithetical to the PCA (Rogers, 1951). A person can only congruently label him/herself alcoholic if that label possesses an intrinsic meaning which dovetails and explains his/her experience at any given moment in time. As a person travels through life, s/he may change the descriptive

label of alcoholic if s/he feels that this no longer matches his/her self-concept (Rogers, 1967).

Through the use of congruence (in conjunction with the other conditions of the PCA) a researcher may assist a participant to symbolise, accurately, his/her understanding of experience (Rogers, 1951); i.e. articulating those experiences which a participant believes match his/her experience and then communicating this to others (Rogers, 1959). Ideally, a participant will perceive or subceive (actively or passively) that s/he experiences, within the interview(s), the researcher's attitude informed by the core conditions (Tudor and Worrall, 2006).

In conjunction with the techniques of reflective listening (e.g. paraphrasing, asking for clarification, etc.) a participant is emboldened in his/her attempt to describe his/her experiences with more precision and, particularly, through the use of highly personal, eidetic metaphors (figures of speech which compare one thing with another) which provide seminal descriptions going to the heart of the phenomenon s/he is attempting to express (Matheson and McCollum, 2008). Metaphors make statements about the way experience is viewed (i.e. what has happened), but also the way that experience is being reflected upon. Keen (1983) argues that this governs perception and can be limiting, but this is to ignore the organismic tendency, so that metaphors may change or be discarded if they fail to provide the right "fit". (I explore the importance of metaphor more fully in Chapter 9).

It is within this process of symbolisation, I suggest, that the PCA noticeably diverges from methodologies currently deployed within the ATRF and reveals its utility for my research question in seeking to gain insight into perception. Whereas current ATRF methodologies, some of which are phenomenological, collate data (experiences) which are then subject to the analytical scrutiny/codification of the researcher(s) in order to ascertain meaning, the PCA posits that the researcher acts, collaboratively, to support a participant in matching his/her remembrance of experiences with the words s/he chooses to describe them.

From this emerge potential themes or personal self-constructs formed through reflecting on experience. These are symbolised by modes of expression (e.g. metaphors) which are analysed, initially by the researcher, to illuminate a participant's

internal frame-of-reference. These tentative descriptions are, subsequently, explored collaboratively and validated or rejected by a participant; the task of sense-making remains solely within the remit of a participant. It recognises that, over time, both the narrative and any meaning(s) derived from it may change, but that this does not make it unreliable. Instead, it indicates the process of change or *becoming* (Rogers, 1961) within a person as s/he strives to match, ever more accurately, his/her linguistic description with experience.

6.14 Limitations of using the PCA

Within a research setting, a PCA researcher may offer a participant the core conditions, if s/he adopts and applies the Rogerian approach, congruently, within his/her way-of-being. However, the potential absence of any rapport or trust (usually established over several meetings within the therapeutic encounter) may mean that these conditions are not immediately perceived or subceived by a participant so that, potentially, their value is diminished. This might affect the quality of the data, not only by a failure to enhance the congruence of a participant but because, without any psychological contact, it may not be possible for a researcher to differentiate between experiences which are being described as lived-truth, (i.e. derived from a participant's congruent organismic self), from those which have emerged from a distorted self-concept and thereby misrepresent lived-experience.

Within research, co-constructing an exploration of meaning relies on a level of synergy (i.e. rapport/trust/psychological contact) between the researcher/participant, the success of which depends on their empathic attunement; this is difficult to verify. Within a therapeutic relationship the effects of person-centred therapy on personality change can be addressed, using either the Person-Centred and Experiential Psychotherapy Scale (PCEPS) (Freire et al., 2014) or the Carkhuff-Truax Scale (Truax and Carkhuff, 1967; Carkhuff, 1969). Neither model was devised, however, for therapeutic research of the kind which this thesis follows.

Given their levels of motivation to engage with the study, the rich descriptions of their experiences and their levels of self-disclosure, I suggest that psychological contact was made with each participant. My recording of my felt-sense (Gendlin, 1984) of each

(this is described more fully in Chapter 9 and an example of my recording of the felt-sense is provided in Appendix 9) suggests that levels of empathic attunement varied; though difficult to quantify, this will have affected the data.

A fuller critique of the limitations of deploying the PCA is described in Chapter 13.

6.15 Chapter Summary

The PCA is a non-directive, person-focused methodology which recognises that participants are capable of describing experience without intrusive interpretation, given their experiencing of a researcher-generated conducive atmosphere of respect and empathy in which they can explore their life-narratives. It gives primacy to the internal frame-of-reference of a person, acknowledging that this changes and evolves over time (Rogers and Stevens, 2002). However, it is not without limitations; the viability of the PCA was, therefore, tested through a pilot study, which is the subject of Chapter 7.

7.0 Chapter Seven: The Pilot Study

This chapter outlines the theoretical purpose for a pilot study and how I used it as a means of: assessing whether my research question had validity; that the research topic was engaging; the feasibility of my methodological approach; what refinements were necessary; and to gauge the level of data which might be expected from the main study.

7.1 Introduction

I employed a pilot study as a preliminary means of testing the overall feasibility of my methodological approach to this study. A principal difference between it and the study proper is that the pilot study involved both an interview session and an hermeneutical analysis of several emails, written over a protracted period of time. This would not apply within the main study which was to be solely interview-based.

7.2 Theory pertaining to pilot studies

From a theoretical standpoint, pilot studies are a "*requisite initial step*" (Leon et al, 2011: 626), applicable to all forms of research (Porta, 2008). They assesses: the validity of the research question; test the feasibility of research methodologies, allowing for their subsequent refinement; and gauge the quality of data which might be expected from the main study (West, 2013). Though pilot study findings are not, necessarily, included within the main study, they ascertain whether the research is practicable, will yield interesting results, with the benefit that, "*a good pilot research interview will show you how deep your data is likely to be and how engaging your research topic and its data will actually be for you*" (West, 2013: 67).

7.3 The use of a pilot study in my research

As I will describe below, preliminary findings of the pilot study suggested that relapse appears not only to be a uniquely subjective experience, best viewed through a

participant's frame-of-reference, but which is amenable to exploration by deploying the principal attributes of the PCA and its skill-set of reflexive listening. Whilst particular themes are discernible within a narrative, these were nuanced and mainly relevant to the perceptions of an individual and were not necessarily transferable to others. The rest of this chapter is an appropriately telegraphed structure summarising the bare bones of the pilot study.

7.4 Aims

My aim was to find a recovering-alcoholic who was prepared to talk about relapse. A friend having relapsed (after three years sobriety) was willing to accede to my request. I used the pilot study to gauge:

- that my research question had validity
- that the research topic was engaging
- whether the PCA methodology was feasible and what refinements were necessary
- what level and quality of the data it might yield (West, 2013).

I address these, in turn, later in the chapter.

7.5 Limitations/Differences with the main study

The form of my pilot study involved an hermeneutical analysis of *in vivo* quotes selected by George (a pseudonym) and me from a collection of general emails (unrelated to alcoholism/relapse *per se*) exchanged over a five month period. Following a standard RPM process, *we* sought to identify selected passages which might indicate antecedents which served as precipitants to relapse (e.g. mood, cognition, events, etc.). Additionally, there were two discussions via skype.

George did not fully match my criteria for the research study. Positively, he:

- self-labelled as alcoholic
- alcohol was his only substance-of-use

- he attended AA
- had a sponsor
- but had not yet engaged with the 12-Step programme.

He had no psychiatric comorbidities of which I was aware.

The confounding variables particular to the pilot study were:

- George was not-European
- he was known to me socially
- since his relapse, he had not been sober for one year
- he could not be expected to know how relapse, comprehensively, would form part of his longer-term recovery.

The pilot study did not involve a semi-structured interview. Problematically, George had experienced an amnesic, *en bloc*, blackout, which hindered his recall of the relapse-event:

"But I had a blackout, nothing, nada; two days just gone. I have a picture of me in my mind taking a shot from the bottle, but could not say if it was this relapse or something that happened when I was drinking before."

This is a feature of some relapses providing no memory of the drinking-event and where memory never returns (Goodwin et al., 1969; White, 2003; White et al., 2004).

7.6 <u>Pilot Study Data</u>

These comprised:

- 2 emails written immediately after the relapse recalling what happened (18th and 20th May, 2014).
- A series of general emails written over a five month period (January to May, 2014) reviewed for relevant *in vivo* quotes which identified potential relapse precipitants
- A recorded skype session (approximately 45 minutes), during which the *in vivo* quotes were discussed

- My written descriptive summary
- A follow up skype session (approximately 45 minutes), at which findings were agreed.

7.7 Data storage and ethical considerations

The nature of the study had been explained to George and he gave his verbal, informed consent. All names were changed for reasons of anonymity/confidentiality. Elements of the transcript were retained, with George's consent, as the only account of this study. All other data were destroyed at his request.

7.8 Method

We reviewed all emails independently and selected *in vivo* quotes which we felt best represented significant relapse-indicators and reflected George's current view of the relapse event. Lists were compared and a selection was made. George was the final arbiter as to what was to be included, as this exercise was ethically mindful that George's need was to return, speedily, to active-recovery. Relapse-precipitants were, consensually, grouped under six headings (see Table 1, below). This was reviewed conjointly in a 45 minute skype session. A detailed transcript of this session was not made, but passages relating to themes were transcribed. A descriptive analysis was then written by me which George reviewed.

The final skype session took place, several weeks later. George validated the findings as an accurate description of what had been discussed. In this final review, by employing the listening-skills of the person-centred approach (PCA), George, additionally, revealed previously undisclosed existential themes which had troubled him:

- feelings of shame
- the forgiveness from his family heightening his own guilt
- his sense of self-loathing
- his identity as an alcoholic

- his need for honesty
- his sense of loss through not drinking.

No longer reviewing this in a formulaic algorithm of relapse precipitants, he employed eidetic metaphors to describe his emotional and psychological experiences of relapse.

7.9 Methodology

The pilot study tested the feasibility of using the listening skills of the PCA and applying the core conditions of empathy, congruence and unconditional-positive-regard (Rogers, 1951), so as to create a safe atmosphere, not unlike that which George could experience at an AA meeting. By reflecting back to him my understanding of what he said, paraphrasing his statements and asking questions for clarification (Tolan, 2008), George was not only able to express, to his satisfaction, his feelings more congruently and accurately, but matched them to his phenomenological understanding and description of his relapse. The methodology was ideographic and phenomenological but obviated the dominance of researcher interpretation. Hermeneutic analysis of *in vivo* quotes was collaborative. Before reaching a co-created phenomenological description of his subjective experiences, this methodological approach also benefited from the time taken between the initial discussion and writing the descriptive analysis, to engage with and benefit from the reflection by both parties.

7.10 Findings

7.10.1 The relapse event

At the time of his relapse George was dealing with: the wedding of his son (and the prospect of becoming an empty-nester); a family funeral; writing a book (which he was hoping to publish); and changing job.

This conclusion of the relapse process (i.e. consumption) is described *verbatim*:

"G: I remember buying the vodka, that was my usual drink, and I put it in the trunk of my car and went to work. It was okay. I just felt, er, okay, nothing great, I didn't feel different, er, just like okay... I have checked with work since and, er, apparently there was nothing weird about my behaviour, it was just a normal day; what I am saying is I wasn't, um, behaving, well differently, you know. I know I left work around 6.20 pm to drive home. The next thing I, I, was... I remember is, er, coming to at the wheel of my car. I was, um, in the driveway and I can just remember this goddam headache and car alarm "whee, whee, whee". I got out of the car. It was covered in, um, mud and I had a flat. I, I think I tried to, er, open the hood but couldn't and collapsed on the drive way. I can remember, um, people around me, I'm, I'm not clear on any of this, er, you know, but I think I, um, recognised my son and there was a blue flashing light. I guess I was sick at some stage. Er, the next thing I remember was, um, waking up in hospital. But this is the bit that frightens me, um...from the Wednesday to, er, when I came round in the car, well it was, er, Saturday. Like two whole days have vanished from my life."

7.10.2 <u>The immediate reaction</u>

George engaged with varying styles of reflective and reflexive evaluation of his relapse, which unfurled over time. We termed these processes *reaction* and *re-appraisal*. Within 24 hours, he had sent me an email detailing his immediate *reaction* to his relapse:

"*I'm in a very bad place at the moment*" (18.5.14).

He feared, potential, consequences particularly that his wife might leave him:

"*I am afraid Joan may have had enough*" (18.5.14).

Surrounded by members of AA, his immediate concern was to stay sober:

"*I have to try and stay sober today*" (18.5.14).

Within two days his mood had changed to a more reflective *re-appraisal* of the relapse and what he needed to do:

"*My priorities are wrong and I have to change that*" (20.5.14).

His family had rallied round; consequently, some anticipated problems were going to be avoided:

"*I am lucky to have many people who truly love and care about me*" (20.5.14).

The worst appeared to be over and he had to rebuild his life:

"... *it could have been worse*" (20.5.14).

In *reaction* and *re-appraisal*, relapse was externalised (*"a disaster waiting to happen" 18.5.14*); contextualised ("*it could have been worse" 20.5.14*); but was also viewed as an internal deficit ("*I lost my sense of priorities" 20.5.14*). It also precipitated a high degree of motivation to change ("*I have to try and stay sober today" 18.5.14*). George assumed responsibility for what had happened and, though not able to achieve this on his own, the support of others (AA) offered him hope:

"*This has been a pattern for me which I thought was behind me, but sadly it's not the case, I've only gotten myself to blame for this*" (18.5.14).

7.10.3 Perceived precipitants to relapse

Reviewing emails between January 2014 and May, 2014 (the time of the relapse) a consensually agreed total of 35 *in vivo* quotes captured those elements which could be interpreted as being relapse triggers. These were grouped under six headings (see Table 4 below).

Table 4	General pre-relapse themes: Daily coping	%
1)	Time Management / Pressure	33
2)	Work and Related Stress	22
3)	Health Issues	22
4)	Family Relationships	11
5)	Drinking Memories	6
6)	Other	6
Total		100

Time management/pressure became the most significant relapse precipitant:

"*I am really run ragged*" (22.4.14)

"*I've been extraordinarily busy these last few days*" (14.5.14)

"*I have a full weekend*" (16.5.14)

Secondly, this lead to increased stress as he tried to accommodate everything into his, already, busy life:

"I am unfortunately overstressed at work these days" (12.2.14)

"*The job front is now entering the unpleasant stage; I feel I'm moving from one stressful job to another*" (28.4.14)

Work pressures, combined with a wedding and a funeral, added to his burdens:

"*I am really run ragged with work, funeral and wedding plans*" (22.4.14)

His motivation to be busy was allied with a sociotropic need for external approval and his belief that, were he to relax (even when necessary), he (and others) would interpret this as evidence of his malingering:

"*... there was something depressingly evocative about malingering at home Monday and yesterday feeling sick and tired*" (8.5.14)

Concomitantly, his emails contained many quotes where George was genuinely ill, but could not (or dared not) consider his health:

"*It's making me feel run down*" (27.1.14)

"*At 2.00am I was besieged with by either a case of food poisoning or stomach flu*" (5.5.14)

His main coping-strategy was to keep active:

"*I find that a mental health requirement for me is to stay active*" (7.5.14)

His family-life was hectic and non-restful:

"*The house is turned upside down*" (26.1.14)

This was because his son and his Norwegian fiancé were leaving home:

"*April and Paul move out on Tuesday. Then Joan and I are empty nesters*" (3.2.14)

Additionally, he was entertaining her Norwegian family, who spoke little English:

"*I have been pre-occupied with my overseas house guests*" (20.4.14)

At one level, he felt that he was coping (i.e. he had not had a drink) but intrusive thoughts about drinking were emerging:

"*If I believed I could control my drinking, I'd take a drink or two every morning!!" (*20.1.14)

There were other irritants which affected his equilibrium. He was struggling to make headway with his book:

"*There is always the darned book*" (15.5.14

Additionally, he had a minor car accident:

"*I just ran into a snow drift packed with ice and punched a hole in my bumper" (*9.2.14)

7.10.4 Data elicited via the PCA

This thematic interpretation indicated, in line with AA (Thune, 1977), the aetiological processes of his relapse gradually developing over time, but provided little insight into George's personal experience of the phenomenon. Using the PCA and its requisite listening-skills, provided the time for a more co-creationist approach to evolve and a third sense-making process to emerge. This enabled him to engage with a more evaluative, non-judgemental, self-appraisal of what had happened.

He expressed, through a series of eidetic metaphors (e.g. battle, the truck, the wall, the hammer, oblivion, etc.,), his humiliation at being alcoholic; his struggle at self-forgiveness and how this was exacerbated by his family's forgiveness of him; his existential battle with his self-created way-of-being; his loneliness and lack of self-worth; and his need for external validation. Relapse was his capitulation to a quotidian struggle against a powerful adversary, which he described, metaphorically, as a wall:

*"... I get this feeling of trying to break through to the other side.... but I've got to get there, and the faster I get there, the better it will be. I could never give myself permission to relax... there is something between me and the corner, something stopping me, or preventing me, you know, getting through to clear blue sky... {a} big wall, which needs to be demolished, only I built the f**king thing and it's so damned big and strong and all I've got is this little hammer."*

7.11 Discussion

7.11.1 Did my research question have validity?

In attending AA, relapse evokes an immediate, supportive response ("*I am with AA friends at the moment*" 18.5.14). If abstinence is the proximal, daily outcome-goal of a recovering-alcoholic ("*I have to try and stay sober today*" 18.5.14), then relapse taught George that the way he was leading his life was flawed ("*My priorities are wrong and I have to change that*" 20.5.14). Relapse caused distal problems by raising significant, legitimate doubts. Could he maintain his sobriety and what effect had relapse caused within his home life ("*I am afraid Joan may have had enough*" 18.5.14)? But, if

abstinence is valued, then George has to make strenuous efforts to understand relapse (which he may fear). Its destructive significance is palpably visible and is antithetical to a sober lifestyle.

My research question appears valid because it addresses, *inter alia*, three key existential and phenomenological areas of *being* which dominate George's life: the phenomena of *alcoholism*; what it means to be *alcoholic*; and what *relapse* represents to him. There is significant extant research which highlights that the study of AA, as an independent self-help population, is legitimate (Ogborne, 1993). Whilst some alcoholics may prefer a medicalised, non-AA route to recovery (Cheney, et al., 2009), empirical evidence equally suggests that AA can be reasonably used in connection with professional treatment, as a means of achieving longer-term abstinence (Kelly et al., 2006).

7.11.2 How engaging was the research topic?

The study graphically illustrated the potential harm and life-threatening nature of relapse, the physical, emotional and psychological agony it produced for George and the responsiveness of different elements of his immediate environment. But, making sense of relapse is intriguing, because it operates on many different levels of being. What does alcohol represent to him and why, when he knows the damage his drinking has caused does he still feel drawn towards it?

"... but I really didn't want to drink, there was none of that craving which I hear in AA, I just wanted some reassurance. I wasn't trying to test myself or any of that crap, just a feeling, like, if it's there I'll be okay."

Resolving this alcoholic conundrum involves: his existential view-of-self; and why alcohol provides that re-assurance which causes him to feel "okay." Significant existential themes of forgiveness, reconciliation, atonement, shame, self-blame, confusion, fear and despair abound within the final co-created narrative on which he reflects. Equally, relapse requires him to address practical issues of maintaining abstinence and the kind or quality-of-life he wishes to create. This necessitates the

development of self-awareness; competent coping-strategies; a quotidian outcome-goal but, principally, an understanding of the profound relationship which George had and (even in early recovery) still has with alcohol:

"Like an idiot I just wanted something to reassure me and like a fricking idiot thought a bottle of booze would be a good idea. Nuts or what?! I honestly never intended to drink, but there is part of me that misses it like crazy, you know, really, really misses it."

My research question is engaging because it is so puzzling.

7.11.3 Was a PCA methodology feasible and what refinements were necessary?

The PCA appears feasible but this study highlighted that collaboration with a participant, though valuable, has practical limitations. Experiencing the PCA's core-conditions enabled George to engage with the process of sense-making, without my needing to be (overtly) directive. George was heavily involved with the sense-making process because of his pressing need to return to sobriety. This will not be the case in the main study and it would be unrealistic of me to expect that same level of engagement. Therefore, I intended to examine those interview transcripts first and then present my descriptive review of them for participant-validation. The PCA trusts in the reflexive abilities of participants to think about the interview, during the time taken to prepare any written findings and again, to reflect on these when they have had time to digest them. The second interview will be a co-created summary of what we have found.

7.11.4 What level or quality of data might the study yield?

The data appeared to operate on two levels. First, a functional sense-making process which helped George's swift return to participation with AA (and its ideology), through the practical way in which he managed his life ("*need to make significant changes to my life*" 20.5.14). These may be relevant to re-aligning him with AA thinking:

"G: But this time, I will keep it simple... It's what AA tells you, go to meetings, admit it when you're wrong, be honest, stay away from the first drink, don't let your ego run riot, being an addict is all about self-will. I was getting complacent, taking things for granted. I let my guard down."

Secondly, it produces a richer level of data which were more existential, idiosyncratic and were expressed through the use of eidetic metaphors (Davis and Jansen, 1998). When George moved away from an algorithmic analysis and into this realm of subjective-meaning, he revealed what it was like for him to experience the phenomenon of change and his internal, psychological battle of being an alcoholic who had relapsed. Relapse repaired a profound sense of loss (derived through abstinence) but it also meant a return to an old destructive way-of-being.

7.12 Chapter Summary

Relapse was graphically illustrated as being an intrinsically personal experience, which can be catastrophic and life-threatening. I suggest that to gain insight into the phenomenon, a methodology must be non-challenging, encouraging and afford a participant time to reflect, as his/her process of sense-making evolves; it does not have to rely on researcher-intuited themes. This pilot study suggests that the PCA extends this reflective process from the initial interview, via the period of time during which the co-created findings are written-up, prior to a secondary collaborative review. This secondary review potentiates the opportunity for a more thoughtful overall description, as the reflexive and reflective processes of each party are brought to bear on the phenomenon.

The PCA enabled George to consider his immediate environmental triggers, derived from *in vivo* quotes and give expression to deeper held existential beliefs, which might not otherwise have been revealed, but which were materially affecting his chances of success. These beliefs were conveyed via eidetic metaphors, as personalised units-of-meaning, providing an insight into his frame-of-reference and did not require elaborate interpretation by me. These results may not necessarily extend beyond the

pilot study and were not intended to be included in the final participant analysis. What they hinted at were the diversity of relapse experiences and the idiosyncratic manner in which they are expressed.

In Chapter 8, I describe my rationale for the study's sample size and problems with recruitment.

8.0 Chapter Eight: Participant Recruitment

This chapter explains the study's recruitment of participants; details the theoretical guidance regarding participant sample-size; the proposed size for this study; and the difficulties encountered in collaborating with AA.

8.1 Introduction

My study focuses on experiences of recovering-alcoholics and because the BACP ethical framework and hospital's protocols debarred me from accessing patients, *post-partum,* my study inclusion criteria determined that participants were to be drawn from AA, a recognised study-population possessing an expertise of experiencing alcoholism and living in sustained-recovery (Ogborne, 1989, 1993).

Negatively, the ATRF views AA with ambivalence (Ferri et al., 2006) and studies involving it are often limited by its tradition of anonymity and non-collaboration, as stipulated within AA literature (Galanter et al., 2012). Positively, AA simplifies any operational definition of relapse regarding it as the ingestion of a single alcoholic beverage. It is an ethnographically defined group with practices, customs and published literature open for analysis. Its interest centres on the phenomenological experiences of being *alcoholic* and living with *alcoholism* (AA, 1976).

Sample-size is not just a matter of arbitrary caprice but needs to be commensurate/congruent with the aims of the study and the methodology chosen. This chapter will describe in turn:

- how access was gained to the participants within the organisational structure of AA
- the method of sampling chosen
- the process of recruitment
- reflections on the sample-size as the study progressed
- and, finally, external problems which determined the final number of participants

First, I will address the theoretical perspectives on sample-size within research literature.

8.2 Theory pertaining to sample size

There is no definitive answer to the numerical question of sample-size (Finlay, 2009). In phenomenological enquiry, Hycner (1985) and West (2013) suggest as few as 3-4 participants, the latter concluding that much depends on the data's richness which, if jejune, will typically result in a compensatory, over-elaborate analysis. If deploying an IPA methodology, Smith et al., (2009) recommend 9-12 participants. Dallos and Vetere (2005) determine size by the need for homogeneity and generalisablity (neither relevant to my inquiry) and, following Smith et al., (1999) include the mental capacity of the researcher to analyse and synthesise detailed accounts from participants. Alternatively, determining sample-size by data saturation (e.g. Glaser and Strauss, 1999) is more properly related to grounded theory rather than phenomenology (Mason, 2010).

Malterud et al., (2015) posit that sample-size is associated with their concept of *information power* which the population sample should provide (linked to the aims of the study; sample specificity; use of theory; quality of dialogue and its analysis strategy, etc.). Marshall (1996) argues for small sample-sizes which illuminate the understanding of complex psychosocial issues, especially where generalisablity is not the ultimate goal. Overall, research guidance is confusing and inconclusive (Guest et al., 2006).

8.3 My study's sample-size

My study's ethical proposal required an *a priori* indication of a sample-size; this was set at 9-12 persons (Cheek, 2000) being, generally, in line with phenomenological inquiry as evidenced within those phenomenological studies found within my literature review (See Chapter 4). It was confirmed, during supervision, as being reasonable and practicable, given my existing clinical practice. It was further believed that it could provide a richness of subjective data (Maxwell, 2013); was suitable for the

PCA; that the volume of data would allow for in-depth, comparative analysis; be sufficiently challenging for the purposes of satisfying the requirements of a PhD (Cheek, 2000); but not be overwhelming, given my employment and personal commitments (Flick, 2007) It was further agreed to review this as the study progressed, forming part of the supervisory (Patton, 1990; Tuckett, 2004) and my own reflexive process (Emmel, 2013).

8.4 Sampling Method

The study's purpose was to garner sufficient data of its participants' subjective lived-experience of alcoholism/relapse (Gaskell, 2000), thereby focusing on meaning-making, the heterogeneities of meaning and how relapse related to their process of sustained-recovery (Dworkin, 2012). As AA affiliates are regarded as vulnerable adults (Liamputtong, 2007), an ethical balance could be achieved if the participation criteria actively sought to reduce distressing confounding variables, usually found within ATRF studies (e.g. vulnerabilities caused through psychiatric comorbidity; socio-economic pressures, legal problems, poly-drug use, etc.,) (Castonguay and Beutler, 2006). At a minimum, my participants would be:

- Adult (18 years, plus)
- Had used alcohol as their only substance of dependence (i.e. there were no illegal substances used)
- Had a sustained sobriety of two years (i.e. a reduced risk of relapse)
- Showed no presenting co-morbidity or other diagnosed psychiatric illnesses.

Consequently, I chose a purposive sampling method, as the most suitable kind of non-probability sampling to identify the primary participants (Palys, 2008). Purposive sampling targets a particular group of people (in this case AA members enjoying sustained-recovery) and provides a useful method when the desired population being sought is: rare; complex; vulnerable; difficult to locate; access; and recruit for the study (Whelan et al., 2009). I also employed a defined set of inclusion/exclusion criteria, (to reduce attracting particularly vulnerable participants) and in keeping with the essentially qualitative approach adopted by this study (Trochim, 2006).

8.5 Operationalising recruitment

AA is the most successful, international, mutual-aid organisation (Room and Greenfield, 1993) being structured so that each individual AA group acts as an autonomous entity:

"Each group should be autonomous except in matters affecting other groups or AA as a whole." (AA, 1952: 150)

8.5.1 AA National Contact

I telephoned AA's UK General Service Office (York) (on 13/3/15) to explain the nature of the study. I was advised, given the autonomy of groups, to make a courtesy call to AA's Northern Service Office (Glasgow) and advise them of my intentions.

8.5.2 AA Regional Contact

The Glasgow office restated that I would need to contact local AA groups individually. For meeting locations I was referred to AA's websites for its regional co-ordinating bodies (these are provided in the Reference Section). Table 5 (below) shows the regional bodies and their corresponding meetings; figures for individual group membership are not available.

Table 5 **AA Regional Body**	**Regular Meetings**
Northwest Intergroup	47
Merseyside and South Lancashire Intergroup	37
Cumbria Intergroup	24
East Lancashire Intergroup	44
Total	**152**

8.5.3 AA Local Contact

For logistical reasons of cost, access and available time, a search-pattern began, centred on my home address in the Fylde Coast and radiating out from that point in concentric circles, with a five mile annulus between each circle. I sourced contact telephone numbers from AA's directory of UK group meetings ("Where to find AA", AA, 2014/2015) and telephoned batches of ten groups at a time.

8.5.4 AA Individual Group Meetings

The nature of the study was explained to the designated group member contacted. If declined, no further contact was made. If my request was to be put to the members, at their next available meeting, I was advised to call back. If, subsequently, refused, then no further contact was made. If, however, a group agreed to my request, I was invited to attend an "open meeting". As a clinician, I am familiar with "open meetings" which are intended for alcoholics and non alcoholics, e.g. "*family, friends and anyone interested in AA*" (http://www.alcoholics-anonymous.org.uk/AA-Meetings/About-AA-Meetings). Their use, for research purposes is endorsed by Steffen (1997) and supported by Whelan et al., (2009).

8.5.5 Meeting attendance

At each meeting I outlined my research proposal and the nature of voluntary participation was stressed; any questions were answered. My contact details and copies of the "Request for Participation Letters", "Informed Consent Letters" and "Semi Structured Interview Questions" were left after each visit (see Appendices 2-4). The meeting was thanked for its time and I would then await any response; the AA meeting was not re-visited.

After two weeks, if there had been no response, the process was repeated and the next batch of ten meetings was approached. These contacts finally yielded *n*= 6 participants (4 men and 2 women) who fulfilled the inclusion/exclusion criteria and were willing to take part in the research. There were three other people who gave

back word (see below). In keeping with AA's principle of anonymity and to safeguard the confidentiality of participants, participant contact details were only known to me.

8.6 Recruitment phases and difficulties: Reflections emerging within the study

8.6.1 Participants 1-2

On commencement, significant disparities emerged between participant narratives and the ATRF's conceptualisation of relapse, as each viewed the phenomenon through the ideographic lens of his/her own idiosyncratic frame-of-reference.

The narrative data was significantly rich, complex and detailed and the volume of representational analytical data generated averaged 90-100,000 words per participant. Consequently, my supervisory team indicated a danger that the study would become overwhelmed by the data being produced. It was mooted that, should this process continue, fewer interviews/participants might be appropriate. This addressed the ethical implications of burdening more research participants than were actually needed and the duty of self-care to the researcher (Guetterman, 2015).

8.6.2 Participants 3-4

As the number of participants increased this variance became more marked, suggesting that data (Francis et al., 2010) or thematic saturation (Guest et al., 2006) was, potentially, out of reach. This was because each life-experience appeared unique so that the data are never truly saturated (Wray et al., 2007) and the emergent descriptive processes are potentially limitless (Green and Thorogood, 2004). Arguably, the phenomenon could never be fully explored within the confines of this study.

A modification to the study's original sample-size was considered. It was agreed that, to date, participants were appropriate to the study and the adequacy of their responses appeared to answer the research question sufficiently (Marshall, 1996) by offering uniquely different perceptions of relapse so that, if necessary, a smaller cohort size could be justified. This was kept under review.

8.6.3 **Participants 5-6**

At this stage, an unforeseen operational problem arose which, effectively, brought recruitment to a halt.

The ATRF acknowledges that AA affiliates are cautious regarding perceived intrusions into their lives (Galanter et al., 2012). I had addressed the ethical requirement to protect the confidentiality of the participants (as vulnerable individuals) when first seeking ethical approval (Morse and Coulehan, 2014). Owen-Pugh and Allen (2012: 269) note that, "*alcohol abusers in recovery are a hard-to-reach group – the stigma associated with alcohol abuse can leave many reluctant to revisit their past*".

The negative effect of stigma (Kairouz and Dubé, 2000; Brewer, 2006; White, 2007) provides a reasonable and cogent argument which makes intelligible why the bulk of ATRF studies take place within treatment-centres and why, with few exceptions (e.g. Vaillant, 1988, 2003), longer-term studies are regarded as being less practicable and not only for reasons of cost (Gossop, 2008), or participant attrition rates (Barr et al., 1984). Consequently, as there exists a lack of empirical data on how recovering-alcoholics experience or make-sense of relapse (Laudet, et al., 2014), this study was providing an initial exploration of an under-researched and ambiguous area of experiencing.

However, my study's recruitment process confirmed a further explanation as to why recovering-alcoholics are reluctant to step forward to discuss their experiences; they have a belief in the requirement of *personal anonymity*, at the public level, which becomes adamantine if it is perceived to be challenged (Blumenthal, 2014). AA (1952) regards anonymity as the:

"... greatest safeguard that Alcoholics Anonymous can ever have" serving as a, "protective mantle which covers our whole society and under which we may grow and work in unity" (AA, 1952: 192).

The need for anonymity, like much else within AA, derives from its collective lived-experience so that the organisation believes that:

"Clearly, every AA member's name -- and story too – had to be confidential if he wished. This was our first lesson in the practical application of anonymity." (AA, 1952: 189)

Even though this ethical consideration was understood and allowed for when the study was initially devised, recruitment was disrupted by an unexpected (and not reasonably anticipated) problem. Officials (from certain Government Departments), posing as AA affiliates, appeared to have been targeting selected AA groups as part of a general crack-down on benefit irregularities. It was explained to me, particularly by those groups within metropolitan areas that, in consequence, members felt that their anonymity had been threatened. Understandably, the number of AA groups, from which it was hoped that participants could be drawn, now refused to countenance any approach for participation and various individuals (*n*= 3), having previously signified their willingness to participate, subsequently withdrew from participation.

8.6.4 Revision of the sample-size

With six participant interviews completed, the sample-size was reviewed within supervision, as it was apparent that no further recruitment might be possible. During the course of the study one participant had, sadly, died but had given her written consent (and desire) for her transcript to be included, though no subsequent validation could be sought from her (see Appendix 10). A sample of six participants (for a study of phenomenological experience) is, however, endorsed by Creswell (1998), Morse (1994) and West (2013). It is regarded as sufficient by Romney et al., (1986: 326) provided that it fulfils two criteria. First, where research participants, being drawn from a specific cultural context (e.g. AA), possess a degree of expertise about the domain of enquiry and, therefore, can demonstrate high levels of "*cultural competence*." Secondly, where the inquiry focuses solely on the perceptions, beliefs and experiences of a phenomenon (i.e. relapse), rather than intending to create a generalisable theory of external truth.

Although participants were longer-term AA affiliates and could demonstrate "*cultural competence*", each was speaking in his or her own right and their interviews and

subsequent descriptive analysis comprised a coherent domain of knowledge (Guest et al., 2006). Guest et al., (ibid) also support *n*= 6 as being a suitable sample-size, but relate this to questions of analyst strategy, competence and the inquires' objectives.

The supervisory team agreed, that a final sample-size of *n*= 6 could be justified and reasoned on the following grounds:

First, it was not an arbitrary decision and transparency could be demonstrated in arriving at this figure. The question of sample-size had been part of the supervisory and reflexive process of the epistemology of the study as a whole (O'Reilly and Parker, 2012).

Secondly, the nature of the research question, based on widely held assumptions of the ATRF, was devised to narrow the research focus, in the belief that relapse was construed as a return to consumption after a period of abstinence. This may have been a hypothesis held by professionals within the field (e.g. Miller, 1998), but did not appear to match the experiencing or definition of the participants. This disparity was a legitimate finding of the study.

Thirdly, the study's recruitment process had been compromised and could not have been foreseen. The study had to be sensitive to the ethical needs of the participants in respecting their wish for anonymity. The specificity of the target group (AA affiliates) could not be altered, because they were the best representatives of the research topic (Morse et al., 2002) nor could the recruitment process be amended. Though a larger sample-size may have been desirable, as with any co-constructed encounter, it was with the data to hand with which the researcher had to work (Hammersley, 1994).

Fourthly, in using a PCA approach, the epistemological basis of the study, (what it sought to learn and know and how the interviews informed this enquiry) was not contingent on a larger sample-size. My study's objective was to try and see the phenomenon of relapse through the eyes of alcoholics in recovery (Rogers, 1959) and was, therefore, based on the broad life-experience of each person's ideographic sense-making of relapse. The phenomenological and iterative approach involved simultaneous sampling, data collection and analysis and then moving from one participant to the next (Bryman, 2012). The study was revealing the fragmentary and

personal nature of a phenomenon which may have points of similarity, referenced between participants, but was not universal.

Fifthly, the pilot study and literature searches had indicated that my research possessed a tentative and exploratory nature, there being no comparable, extant studies in this area of phenomenological experiencing and, as a resource for participation, AA was not widely utilised. The concept of data-saturation, more relevant to grounded theory, (O'Reilly and Parker, 2012) leading to confirmed, generalised, homogenous theoretical pronouncements was also antithetical to the study, as no nomothetic inferences were intended to be made to a wider population. The extensiveness of the variability between participant's experiences indicated that, potentially, there was no upper limit to the sample-size. Further useful data could be found, but the data analysis, being currently generated, was significant (c. 90-100,000 words per participant) which, potentially, could make the study unwieldy. This also contributed to the final rationale for accepting the restriction of the sample to six individuals, even had further recruitment been possible.

Finally, the nature of the research question had aimed at a narrow research focus and the study was geographically restricted within the North West of England for practicality and cost. Each participant's narrative served as an individual case-study providing information-rich data which, having been re-presented in the descriptive analysis, was subsequently refined by the secondary validation interview. The scale of the fine-grained analytical process for each participant was, therefore, doubled and the study had to be mindful of the realities of the researcher's time and resources, given the high premium being placed on the quality of representation from the data generated (Gaskell, 2000). The supervisory team agreed that rather than try to mimic a quantitative representative logic by increasing the sample-size (if this had been possible) it was acceptable to remain with a smaller sample-size (n= 6) and create sound qualitative insights.

Table 6 (below) details each participant's gender; age; estimated length of active drinking; current length of sobriety; and the time elapsing between their initially getting sober and their last relapse:

Table 6 Participant	Gender	Age	Estimated years of drinking	Period before relapse	Current length of sobriety (years)
P1	Male	51	10	7 weeks	4
P2	Female	65	3	7 months	3.2
P3	Male	42	26	Daily	5
P4	Male	69	12	4 months	5
P5	Female	72	c. 40	2 years	3.75
P6	Male	59	20	Daily	3.5

8.7 Chapter Summary

The recruitment of suitable participants proved problematic and directly impacted on the study's sample-size. Sample-size considerations involve two concerns: extensiveness (to generate sufficient data); and appropriateness (or relevance) of the participants. As AA affiliates in sustained-recovery and matching the study's criteria, the participants were appropriate to the research question and the level of the fine-grained co-constructed description was rewardingly but, unexpectedly, high (O'Reilly and Parker, 2012). Though the sample-size was part of the iterative series of decisions and reflexivity within the study (Emmel, 2013) the final number (*n*= 6) was unforeseen and not intentional (Onwuegbuzie and Leech, 2007). As recommended by Guetterman (2015), a critical reflection on this question is deferred to the chapter on the study's limitations (see Chapter 13).

Chapter 9 describes my systematic process for analysing and re-presenting the participants' narratives.

9.0 Chapter Nine: Data gathering and method of descriptive analysis and validation

This chapter triangulates the PCA research philosophy; the rôle of interpretation and the thematic analysis of the participants' interviews. It addresses three research areas: data gathering (the interviews); the process of data analysis; and participant-validation. It examines, therefore, the structure of the two interviews which were used, first, to gather data and, subsequently, validate my findings. The importance of the felt-sense and metaphor within the analytical process is explained.

9.1 Introduction

Clinical practice supported by sound empirical research is a prerequisite for health disciplines including psychotherapy (Wilkins, 2010). In short, interventions are applied because their effectiveness can be adequately demonstrated. The PCA community has addressed this either by: following non-person-centred but positivistic research methodologies, thereby affording its research credibility beyond the PCA tradition (e.g. Baggerly et al., {2010} who used quantitative data analysis to explore the Rogerian conditions of empathy, UPR, congruence and self-actualisation demonstrated within child play-therapy); or using non-traditional qualitative methodologies (e.g. IPA) which are broadly aligned with the philosophy of PCA practice (Reid, 2010). Either of these alternatives acts as a compromise as the removal of human error variance, intended to eliminate bias and increase the rigour of research findings, is problematic for the PCA, as to do so increasingly distances its research from the daily realities of clinical practice (McLeod, 2011) and a participant's "*perceptual field*" (Rogers, 1951: 484).

The ATRF devotes considerable resources to understanding the predictive nature of a penumbra of variables which can potentiate the acquisition of addiction; frustrate treatment; or impede recovery by triggering relapse (Castonguay and Beutler, 2006). However, I suggest that participants are more than a collection of variables (cf. Bergin, 1997) and that my perspectives, as a practitioner, can be used to attend to the relational qualities of the research process, especially where a collaborative approach triangulates its findings with the, additional, expertise of the participants through the

use of member-checking (Lincoln and Guba, 1985). In this way, the *person* is placed at the heart of research thinking, which influences all aspects of PCA academic practice (e.g. framing the study; selecting a methodology; etc.) including identifying sympathetic data analytical methods which rely, in part, on a researcher's personal qualities (Reid, 2010).

The requirement exists, therefore, to make transparent the process by which data is analysed and conclusions are reached especially where such findings will translate into clinical practice. This chapter explains the step-by-step approach I undertook in terms of comprehending the subtleties of the raw data so that I could represent, accurately, each participant's narrative and his/her understanding of the shape in which the process of relapse evolved. It was by this means that a participant's dialogue-with-self could be revealed, which confirmed him/her in his/her current abstinence-based lifestyle.

9.2 Theory pertaining to data analysis and the PCA

Within the PCA, little detailed guidance exists suggesting how to analyse research data (Dewing, 2002). Consequently, data may be gathered using PCA attributes only for the analysis to follow more traditional phenomenological methods (e.g. Clarke, 2014). This means, however, that the researcher fails to sustain a congruent Rogerian approach throughout the processes of both data collection and subsequent analysis (Mearns and McLeod, 1984).

A PCA analytical process is generally viewed as an unfolding, iterative reflection on an individual narrative which is conducted in much the same way as practitioners view treatment (Reid, 2010). Berkowitz, (1997) suggests that this process should be disciplined and completed systematically, focusing on questions such as:

- What specific patterns or themes are emerging?
- Are there deviations?
- What interesting stories emerge and how are they being portrayed?

But the emphasis remains always within the Rogerian tradition of prizing the complexity of an individual embedded in an, equally, complex series of relationships and experiences (Barrett-Leonard, 2003).

Mearns and McLeod, (1984) hold that the primary features of PCA research are that:

- the power dynamic is shared equally between researcher and participant
- the goal of research is phenomenological as, by its analysis, it explores and seeks to understand/interpret, accurately and empathically, the subjective frame-of-reference of a participant
- research is an evolving process and not focused on outcome, i.e. it does not seek to understand the essence or generalisablity of a phenomenon
- the application of the PCA is applied congruently, throughout all stages of the research process
- and a participant's experiences are accepted, non-judgementally, as statements of his/her current belief-system.

I applied both these viewpoints, by adopting an analytical approach which was systematically applied to all the participants' narratives, (an example of the analytical process is provided in Appendix 12) but which equalised the power dynamic between researcher and participant holding that each party was "expert" in his/her respective field.

9.3 Triangulating between the PCA, interpretation and thematic analysis

The phenomenological studies within my literature review (Chapter 4), sought to understand the essence of a phenomenon, *per se*; i.e., they were *phenomenon-centred*. By concentrating on an hermeneutical analysis of participant transcripts, researcher(s) coded data to create sub-categories of themes, which were then reduced to reveal a set of super-inordinate themes which could be applied, collegially, to their research participants.

The analytical and insightful skill of the researcher helped create: either a substantive new theory about the phenomenon under review grounded in the data (e.g. Brudenell, 1997); or shed new light upon the phenomenon (e.g. Smith, 1998) by *giving voice* to

the researcher-interpreted experiences of the participants. This held that the value of a person's subjective experience was enhanced by being placed within the aggregate of other participant experiences as they illuminated the phenomenon. Hence findings could, *ceteris paribus*, be legitimately applied to other contexts and individuals.

In contrast, the PCA does not define interpretation as being reliant, exclusively, on the hermeneutical investigation of a written transcript, but incorporates elements derived from the totality of the encounter between two persons. Every stage of that inter-personal encounter forms part of the interpretive, analytical process. Nor is the focus of the PCA to understand a consensual appreciation of a phenomenon. The PCA is termed *person-centred* because it views lived-experience and the subjective perception of that experience as being directly linked to the innate tendency of an individual as s/he self-actualises and how this process affects his/her self-construct(s) (Rogers, 1959). The self-actualising tendency and its concomitant self-constructs are, intrinsically, unique and not transferrable to another.

Comparisons may and were made between participants, but this did not aim for homogeneity of experiencing; rather it highlighted the multifarious perceptions which individuals may hold regarding an experience. Conversely, identifying homogeneity of process (i.e. that alcoholism and relapse took place within a person's lifespan; participant recovery was guided by AA membership; that there was a move from active alcoholism to sustained recovery) was possible, but did not assume that this process was collegially experienced.

Being phenomenological, the PCA is part of an interpretivist paradigm but does not rely on the sole discretion of the researcher's judgement. His/her rôle is not to elicit or discover meaning by induction. This is the domain of an individual and whatever meaning is ascribed to experience is attended to, by the researcher, by his/her use of the core conditions. Synergies may exist between the PCA and phenomenological analytic strategies, for example:

- line-by-line analysis of the expressed claims and understanding of a participant (Larkin et al., 2006)
- identification of emergent patterns or themes
- a dialogue between the researcher and these themes/patterns

- the use of supervision to audit and test the coherence and plausibility of the research (Smith et al., 2009).

But PCA analysis goes beyond the hermeneutical engagement with a written text (i.e. the transcript) and adopts multiple perspectives in order to perceive and so describe the experience of the phenomenon via an individual's frame-of-reference. This extends to the initial encounter being, as far as is possible: non-directive within the interview process (Rogers, 1945); using the core conditions and skills of paraphrasing or reflection during interviews (which are potential forms of interpretation) in order to assist a participant to symbolise/interpret, accurately, his/her experiences (Rogers, 1961); trying to create a non-challenging and conducive atmosphere wherein a participant experiences an equalising of any power dynamic inherent between researcher and interviewer (Mearns and McLeod, 1984).

In creating my descriptive analysis of an individual's subjective experience, I also used my felt-sense (Gendlin, 1984). The felt-sense is more than a skill of interpretation; it serves as an empathic attunement between researcher and participant which is somatically-experienced and which leads to, potential, new insights. Finally, the data analysis was collaboratively reviewed before the final descriptive representation of the participants' individual experiences was produced.

The PCA is both an ontological way-of-being for its practitioners and, epistemologically, a way of approaching research which, whilst attempting to comprehend the phenomenological field of its participants, responds to them as individuals rather than as a data-set or as members of an homogenised group (Reid, 2010). In creating an interpretation of their experience, the PCA recognises that:

- themes represent personal constructs or aspects of fluid configurations-of-self (Mearns and Thorne 1995) emerging from a person's self-actualising process, rather than data which are treated as part of the overall unificatory process of a person's definitive sense-making.
- the emergence of themes/patterns is subjectively unique to a person's self-awareness in terms of their process of *becoming* (Rogers, 1961) and, being set within the organisational structure of their life-story, describes how a person's

self-concept undergoes a process of change, hopefully towards a state of becoming fully-functioning (Rogers, 1961).

- divergence and convergence (within themes) relates to an individual and are not noted in order to find a commonality across multiple cases (Westen and Weinberger, 2005).
- the researcher's rôle is not to make sense of the narrative as s/he single-handedly interprets it (Tudor and Worrall, 2006) but assist a participant in describing/interpreting his/her experiences accurately, so that s/he can match, congruently, his/her self-narrative with any meanings derived from his/her experience.
- the PCA aims to develop a tentative (non-authoritative) narrative re-presentation of a participant's internal frame-of-reference. This is achieved via an empathic reflecting-back to a participant of the researcher's reflexive description of his/her life-story which a participant will consider, refine and, hopefully, validate.

I now explain the temporal sequence of my process of data-gathering/transcript preparation, followed by my analytical methods and participant-validation. This involved several discrete processes. Data gathering included the initial interview, its recording and the creation of a transcript. Descriptive analysis involved using the analysis of the first participant for comparative purposes between all transcripts; my use of the felt-sense which was recorded; and a focus on the subjective use of metaphor. I describe these in turn.

9.4 **The Process of analysis:**

9.4.1 **Data gathering: The Initial Interview**

One-to-one interviews were held at a mutually convenient time and venue. Each participant received a further copy of the semi-structured question sheet, at least one week prior to their interview, thus giving him/her time to marshal his/her thoughts. Each was asked if s/he had read and understood the Informed Consent Form and confirmed this by signing a copy and initialling each paragraph (See Appendix 3).

Meeting just prior to the interview involved a general unfocused discussion, at which point I disclosed something of my personal and professional background. This ethical use-of-self aimed to establish a rapport with a participant and commence an empathic, non-judgemental and congruent relationship (Rogers, 1951).

The purpose of the interview was to uncover a descriptive narrative-picture of a participant's experience, complete with the rich detail and context which shaped his/her experience (Sorrell-Dinkins, 2005). The use of the PCA's attitudes and questioning style meant that this co-constructed exploration (given the *caveat* regarding empathic attunement described in Chapter 6) was orientated towards perceiving the respondent's frame-of-reference (Rogers, 1951).

The use of semi-structured guideline questions provided a framework for the interview process and allowed a participant, "*to provide a detailed account of the experience under investigation*" (Smith et al., 2009: 59). The questions were asked, sequentially, except when a narrative had naturally progressed, or when a particular question appeared to have been previously answered.

This being a dyadic and dialogic encounter, mine was not a passive rôle, (Sorrell-Dinkins, 2005) as participants were actively asked for points of clarification or had reflected back to them what they had said in order to symbolise, more accurately, their experiences (Rogers, 1961). From time-to-time, additional unstructured questions, emerging from the co-constructed dialogue, were asked but, when this happened, they were highlighted by me as being outside the semi-structured format. A participant had the right not to answer these. For example:

"R: It's not on the on the question sheet, but if you don't want to answer it's, it's fine. How do you think relapse affects the family?" (P2: 634-635)

Interviews lasted between 39.34 and 58.46 minutes and ended when a participant felt that s/he had exhausted the subject area. Table 7 details the length for each participant's initial interview:

Table 7 Participant	First Interview date	Time/Minutes
P1	03/03/16	56.57
P2	22/04/16	58.46
P3	28/06/16	48.48
P4	30/07/16	58.13
P5	26/10/16	39.34
P6	11/11/16	40.10

9.4.2 Recording and transcript

Interviews were recorded on a hand-held electronic recorder from which I typed a word-for-word, anonymised transcript to enhance the accuracy of data collection (Silverman, 2006). This was itself a form of descriptive analysis (Ryan and Bernard, 2003) but is mentioned here as it formed part of the gathering of the data. Non-verbal information was included (e.g. pauses and displayed emotions) being recognised as critical to the trustworthiness of qualitative research (Easton et al., 2000). When complete (usually within two weeks) the transcript was sent to each participant for him/her to see what s/he had said and be reassured that s/he could not be identified from the transcript. Their ability, at this stage, to make discrete alterations to the transcript to protect their anonymity (or withdraw from the study) preserved their ethical right to autonomy.

9.5 Descriptive analysis

9.5.1 The use of the first participant's data

I intentionally used the data of Participant One (P1) to provide a comparative analytical framework which could then be replicated (systematically) in my review of the remaining narratives. (An example of my analytical process using the first participant is provided in Appendix 12). To avoid sampling bias, I did not assume that P1 represented the sum of all possible categories of experiencing. He served as a point of triangulation, not in order to produce thematic homogeneity, but to identify points of

difference within the various understandings of the phenomenon which highlighted the uniqueness of an individual's frame-of-reference.

I chose not to use computerised analytical packages as for six participants and the methods I was using (i.e. an encounter between persons involving some form of interaction and psychological contact (Rogers, 1980a) they were not felt necessary. Instead, for each interview/transcript I used a record of my felt-sense and, secondly, focused on the participants' use of metaphor. These I explain as follows.

9.5.2 A record of my felt-sense

Following each interview, I wrote a reflexive statement detailing my underlying *felt-sense* or embodied-experiencing which captured a participant's immediate, empathic impact on me and my evoked response to him/her; an example is provided in Appendix 9. The felt-sense is more than simply a cognitive analytical appraisal of data, but the total response of one organism to another (Rennie and Fergus, 2006) which includes some thought-like content.

I use the phrase *felt-sense,* properly coined by Gendlin (1964), to describe what Rogers (1951: 76) termed as "*emotions which have been viscerally and physiologically experienced*." The *felt-sense* is, perhaps, less of a feeling and more of a responsive or somatic sensation, which "*is a body sense of meaning*" (Gendlin, 1978: 11). In developing the felt-sense, as a means of focusing on experience, Rennie (1998: 71) describes it as the "*sounding board*" or spontaneous, holistic impression or "*flavour*" of what has been said as it impacts upon a person (Rennie, 1998:50). I acknowledge that there are many different ways of "*seeing*" the data through the use of differing methodologies (Dey, 1993: 111) and the felt-sense as an "*experiencing dimension*" has become a major undercurrent in PCA thought (Ikemi, 2005: 34). Via the felt-sense I tried to discern the "*echo*" (Rennie, 1998: 50) of a participant's frame-of-reference. I deployed it to identify personal constructs or units-of-meaning, uniquely relevant to each participant.

In PCA terms this is less of an act of interpretation (e.g. via the intentional use of hermeneutical analytical coding or a cerebral act of meditation), but an inward process

or gradual emergence of a bodily sensation which develops as one attends to the whole narrative (Gendlin, 1984). It is a self-responsive process which is checked and re-checked as one concentrates on the *quality* or *fit* of the felt-sense and the words/themes/constructs that emerge to describe it. Whilst a nexus of words is implicit in feelings, the felt-sense may be difficult to symbolise but accurate descriptions gradually emerge, with increasing clarity, as the felt-sensed is focused upon.

The benefit of recording this first impression was that it served as a point-of-reference against which all subsequent iterative analysis and reflexivity could be measured (i.e. this is how I felt then/this how I feel now) and so reduced the problems of selective memory recall (Rennie, 1998). For example, my initial felt-sense suggested that P6 understood the concept of fear but, within his self-construct, it was a word which did not feature in his lexicon. He, subsequently, confirmed this during his validation interview:

"P6: ... that's how I thought of fear I didn't think that fear applied to me, as soon as it was suggested that anxiety was a a different word for fear in some ways I began to realise that I was anxious, I, I suffer from severe anxiety, albeit I kept it at bay by drinking..." (P6VT: 80-82)

Practically, during the analytical process, re-reading my record of the felt-sense kept my initial impression of a participant alive and, thereby, helped maintain a person-centred dialogue between me and the data. Consequently, my initial impressions provided contextual data for the more analytical phase of the research, thereby enhancing the thick descriptions ("*rich in details so that it comes to life in the eye of the reader*", West, 2002: 265) required by qualitative research (Rodgers and Cowles, 1993). My embodied felt-sense was, ultimately, reflected back to each participant via my descriptive analysis of his/her narrative.

9.5.3 <u>The significance of metaphor</u>

Whereas other phenomenological studies explore metaphors to aid the creation of unitary or collective themes applicable to all study participants (see Chapter 4: e.g.

Matheson and McCollum, 2008; Shinebourne and Smith, 2010), in the analysis of the transcripts my study explored metaphors as representations of subjective experiences, thoughts and behaviours (Lakoff and Johnson, 1980), to highlight the heterogeneity and uniqueness of experience as expressed by individual participants. Consequently, I recognised that within the narratives two categories of metaphor existed; AA-derived and eidetic. An example of my exploration of metaphor is provided in Appendix 13.

9.5.4 Eidetic metaphor

The PCA regards metaphor as a person's symbolic attempt to re-create meaning which is linguistically made visual or "*concrete*" (Rennie, 1998: 45). The metaphor encodes sensory experience, prompting a descent into a sometimes "*unconscious*" (Casement, 1985/2008:41) or "*out of awareness*" (Worsley, 2002: 81) levels of feeling, as a participant seeks to describe the personal quality or intensity of an experience (Mearns and Thorne, 1995). Eidetic metaphor potentially unites or distils other still more complex, inexhaustible, yet emergent schemas of meaning (Angus and Rennie, 1989). Its use within a narrative not only helps communicate a series of events, but conveys detailed information about the perception of the narrator (Goncalves, 1995). It emerges from the totality of a person's organismic self and describes a phenomenon from his/her frame-of-reference allowing a listener to gain insight into that frame-of-reference as it evolves (Tudor and Worrall, 2006).

In PCA terms, when revising the self-concept through a narrative life-story (which in itself can become an extended series of metaphors), a metaphor is a significant means of increasing a participant's congruence (Worsley, 2002) as s/he seeks to attain a "*unitary and coherent life story"* (McLeod, 1997: 82). Therefore, metaphor is both a narrative theme and, simultaneously, a unit-of-meaning (McLeod, 2011). But it "*would be a travesty of the phenomenological approach*" for the PCA researcher/practitioner to interpret these purely from his/her own frame-of-reference (Worsley, 2002: 82), thereby reifying or ascribing objective reality to that which is a construct of a developing perception of another person's sense of self (Gannon, 1984).

9.5.5 AA-derived metaphor

Additionally, there exists ample testimony regarding AA's use of metaphor e.g. powerlessness (Matheson and McCollum, 2008) to describe the phenomenon of *alcoholism* (Weinstein, 1992) and the developmental process of an alcoholic's identity into one of being-in-recovery, as well as committing and homogenising an individual to the collective ethos of the group (Rafalovich, 1999). The participants' use of AA metaphors may have helped equalise them as sharing the same condition (O'Halloran, 2006); reflect their differences from the social world of non-alcoholics (Landau et al., 2009); but also express the finitudes of an alcoholic identity (Davis and Jansen, 1998).

Though such metaphors may indicate legitimate units of general sense-making to AA members, this should not obscure significant variations within that sense-making which were, idiosyncratically, revealed in a participant's use of eidetic metaphor (Hycner, 1999). My descriptive analysis, therefore, responded to both types of metaphor with the *caveat* that the eidetic, being self-created, was judged more likely to be closer to the participants' frame-of-reference.

Using P1, as a phenomenological template, his use of eidetic metaphors lead to identifying certain experiential categories of his reflexive process and sense-making which surrounded his relapse and which could then be labelled within his narrative description (e.g. fear/despair/hopelessness). These were then extended, for comparative purposes, to all other interviews and set the scene for further data organisation across all the participants. But it also evinced other categories of experience (e.g. P5's feelings of guilt) which were particular to each participant as well as eidetic metaphors which sought to illuminate their subjective experience. Even where experiences appeared similar, (e.g. affiliation with AA) the experiencing of these categories was notably subjective, which reinforced the notion of difference.

In support of my exploration of metaphors, I would further cite the experiences of my clinical practice and the Pilot Study (Chapter 7) both of which bear testimony to their importance when attempting to ascribe meaning to a phenomenon which may be difficult to symbolise by any other means.

The process of analysing and representing the data followed the same pattern for each participant. Each transcript was approached in eight sequential stages which are explained below.

9.6 The eight stages of process for my descriptive analysis

9.6.1 Stage One: attentive listening

Each transcript was read several times with its accompanying recording and a general sense of *what* was being said (the intent of the narrator) and *how* it was being said (the narrative) was garnered. The process of listening repeatedly to the recordings became part of my descriptive analysis (Ryan and Bernard, 2003).

9.6.2 Stage Two: an initial summary

I wrote a general summary for each narrative, a cumulative description derived from my frequent listening to the recording, accompanied by the transcript. This was a broad descriptive analysis based, primarily, on my felt-sense which detailed my initial impression of the discourse but which would form the basis of a later in-depth exploration of the narrative. This section included *a priori* assumptions I had made concerning each participant.

9.6.3 Stage Three: fragmentation

I then fragmented the text into discrete blocks-of-meaning determined by the richness of the data. A tentative exploratory, line-by-line analysis was followed, noting: descriptive comments; the functional aspects of language (e.g. pauses, laughter, voice tone, repetition, degree of fluency, shifts in topics, etc); and anything of interest within the transcript, (e.g. unusual words/phrases) which identified the ways or constructs by which each participant described their world and experience. In particular, I noted their use of metaphor (see below).

The narrative was, at this stage, compared with ATRF research and corresponding points of interest were recorded. Initially, this was a process of questioning naïveté from my own prior theoretical understanding of the phenomenon under review (Charmaz, 2006), but followed the "as if" principle of the PCA (Rogers, 1959). The question I was asking was, "What does "X" want to tell me about him/herself?"

Whilst the PCA adheres to no particular model of data analysis, allowing for an idiosyncratic approach, I followed a process of:

- an interplay between the felt-sense and the narrative (writing down what emerged when reading and questioning the text)
- linking emerging themes to the way a participant described his/her self-construct as an alcoholic
- noting the way a participant described emerging themes (often through metaphor)
- and self-questioning as to why I viewed the specific textual elements I had highlighted as being important.

Ultimately, all such emically described themes would be verified by the participants as matching to their own understanding of their self-constructs within the process of self-actualisation, or not; participant-validation aided the credibility of the study (see Chapter 11).

9.6.4 Stage Four: establishing personal constructs

The narrative was now reviewed on its own merits, i.e. without any reference to ATRF theory. Whilst I would have preferred this part of the analytical process to have been more collaborative, the pilot study had indicated that this might impose an unnecessary burden on the participants' time and resources (See Chapter 7).

At this stage I identified personal constructs which seemed to be particularly important to a participant in understanding and perceiving the phenomenon of relapse and integrating the experience into his/her life as a recovering-alcoholic. For example, in the case of P1, this entailed his need to "*legitimise*" (P1: 222) his relapse (a process not of sense-making but justification), but which mandated that he must remain abstinent.

9.6.5 Stage Five: exploring the world of metaphor

I now attempted to move closer to perceiving the world of alcoholism through the eyes of the narrator. I examined the narrative's purpose (i.e. how it explained and revealed the participants' inner world) (Berkowitz, 1997), but above all the methods employed by the narrators to achieve this. This section paid particular attention to the participants' use of metaphor, which I grouped under the categories of eidetic and AA-derived.

AA metaphors were confirmed using a web site designed for study of AA's *The Big Book* (AA, 1976) (http://www.whytehouse.com/big_book_search/). To a non-alcoholic, AA metaphors require some decoding, as such, they may be characterised as the organisation's "*indigenous categories*" of meaning (Patton 1990: 306). Their use reveals either a member's depth of affiliation to AA's ideology, being part of AA's cultural descriptive schema of alcoholism or that s/he believes that they adequately summarise the phenomenon being described (Galanter, 2014).

AA metaphors were compared with personal/eidetic examples which represented the subjective experiences, thoughts and behaviours surrounding relapse (Lakoff and Johnson, 1980). These were employed to express or, perhaps, imply the cognitive or somatic (felt-sense) of the narrator's experiences (Hendricks, 2007), which imparted a flavour, or created a mental picture of that experiencing, which could be shared/interpreted *as if* the listener was present at the moment of the experience (Rogers, 1959). Metaphors brought the historic lived-event to within the present dialogic moment and rejuvenated it with a sense of "*immediacy*" (Merry, 2004: 125).

Table 8 (below) shows the number of metaphors used by each participant:

Table 8 Participant	AA Metaphors	Eidetic Metaphors
P1	13*	46
P2	2	27
P3	4	37
P4	4	67
P5	5	84
P6	3	102

*****_This significant use of AA metaphors by P1 is accounted for by his particular view of AA, whereby he described the camaraderie, fellowship and his sense of being amongst survivors, which appeared to be particularly significant for him, but not so for other participants._

9.6.6 Stage Six: assembling the temporal biography

In the course of an interview, narrative discourses are often presented in an unstructured and disjointed fashion (McLeod, 1997). In the light of my tentative understanding, gained from my analysis to-date, I now re-wrote each narrative as a linear, temporal biography. This contextualised a participant's historic experience of relapse in terms of describing how s/he understood it relative to the phenomenon of being alcoholic.

The PCA addresses the process of *becoming*, believing that a person makes sense of the present based on experience of what has happened in the past (Rogers, 1961). This stage brought further insights to the narrative by viewing relapse in its historical context within a participant's lifespan. I re-arranged the narrative-data under four temporal phenomenological areas of process which Takeda et al., (2013) deem common to alcoholism, but which was also suggested from the narrative of the first participant:

- Events and precipitants leading to the consumption of alcohol (the relapse)
- The drinking experience and its ensuing physical / emotional / psychological / social consequences
- The revisionist or sense-making process

- The life of sobriety post relapse and the change into an abstinence-based recovery lifestyle.

Relevant metaphors and personal constructs were noted as they applied to each temporal stage of the participants' process.

9.6.7 Stage Seven: highlighting an historical, sequential format

The understanding brought by re-writing the narrative, in a historically sequential pattern, now enabled me to note the process of change which each participant felt towards the existential aspects of his/her experiencing of alcoholism/relapse. For example, the temporal historical account revealed that, over time, P1's view of self had progressed from tonic and phasic states of *"fear*" (P1:6); "*despair*" (P1: 95) and "*hopelessness*" (P1: 97) which, on one level, precipitated his drinking/relapse. Whereas in recovery, he graduated towards expressions of feeling "*acceptance*" (P1VT: 88); "*gratitude*" (P1VT: 12); and living on a "*spiritual plain*" (P1VT: 380) governed by a need to help others. This gave his relapse a subjective value which helped him to sustain recovery. As the PCA views a person as an organismic whole, account was taken of how participants expressed changes in their physical, social, emotional, cognitive, psychological and behavioural processes of daily living.

9.6.8 Stage Eight: Summary and conclusion

This took the form of a general summary and conclusion to the descriptive analysis which, together with my working notes, showed how I had formed my descriptions; these were sent to each participant for validation.

This completed the first stage of the descriptive/ analytical process. I now outline the validation process of member-checking which involved both a recorded interview and the creation of a transcript.

9.7 The Validation Process

9.7.1 Validation interview

Each participant was sent a copy of my descriptive analysis and afforded the time s/he felt necessary to read and reflect upon it. A second, voluntary interview was arranged at a mutually agreed time and place. Each participant was invited to confirm: his/her agreement that s/he had not been misinterpreted; that s/he felt that s/he was suitably anonymised; and supply personal data (i.e. gender; age; length of sobriety; and ethnicity). (An example of a validation consent form is provided in Appendix 6).

These interviews allowed for a frank exchange between researcher and participant; points of agreement or divergence were noted. It was recorded as before and an anonymised, word-for-word transcript made but not analysed. The interviews did not seek to collect new data, but sought to make transparent and auditable (to a participant) my reasoning behind my descriptions and thus serve, to refine or amend the descriptive analysis in a co-constructed manner. Being explanatory, it was semi-directive. On the one hand, participants were given free scope to provide a critical appraisal of their data; on the other, I explained and sought clarification of my findings from them, via questions prompted by me.

Following this interview there was an additional one month "cooling-off" period, during which participants could withdraw their data from the study; that month having elapsed it would be included. It was now that all participant contact details were destroyed.

The relative merits and demerits of member-checking are reviewed later (see Chapter 13 Limitations) but the authenticity of my study's descriptive analysis and the reliability of its findings were felt to be contingent upon participation validation, as recommended by Patton (1990). This also served as an ethical research principle supporting the participants' rights to know how their data was being used (Lincoln and Guba, 1985). Validation was voluntary and participants were allowed to take as long as they required for this process. Consequently, time between the first and second interviews varied between 7-22 weeks (see Table 9). Sadly, one participant (P2) died so her interview was not validated. Another (P4) was too ill to attend a second interview but, instead, supplied a validation letter (see Appendix 11).

Table 9 shows the dates between the first and second interview and the time taken for interviewing:

Table 9 Participant	First Interview	Gap/Weeks	Second Interview	Time
P1	03/03/16	12	26/05/16	36.25
P2	22/04/16	0	None	Died
P3	28/06/16	12	21/09/16	35.24
P4	30/07/16	0	None	Letter
P5	26/10/16	7	14/12/16	36.24
P6	29/10/16	22	05/04/17	45.44

My working notes, descriptive analysis and the participants' second interview transcript were now used to write the final re-presentation of their experiences of alcoholism/relapse.

Chapter 10 presents my descriptive re-presentation of the participants' narratives.

10.0 Chapter Ten: Findings

This chapter re-presents the narrative descriptions of each participant. Their use of metaphor, in particular, gives insight into their phenomenological field, which, in Rogerian terms, is to see their world through their frame-of-reference (Rogers, 1951, 1959). A brief summary of each narrative is provided.

10.1 Participant 1

P1 is practising Christian whose only daughter, at the time of his relapse, was getting married. An engineer by training, his image-of-self (self-construct) is that of a rational man-of-science:

"P1: ... My training is as an engineer and, er, I have a degree in physics as well, so there are rules to apply..." (P1: 255-256)

He puts great store in his cognitive abilities ("*decisions are based on fact, rather than believed facts." PVT1: 246-251).* Married with one daughter, who was planning her wedding at the time of his relapse, he has been a practising Christian since childhood, finding Christian teachings conducive to his lifestyle:

"P1: ... I'd been Christian since I could remember going to church from being 5 and 6 years old, not with my parents just by myself, er, and enjoying the cubs, scouts and everything and I really enjoyed church..." (P1: 137-139).

Part of his self-image was his need to succeed in life:

"P1: ...I always needed to be the best, I always needed to be the best salesman...

R: Yeah.

P1: ... I always needed to run the faster time, I always needed to be out in front..." (P1VT: 201-203)

Being "*good enough*", however, was insufficient as he was driven by his need to excel; to have a sense of purpose or "*direction*" (P1: 56); and to gain the respect and approbation of others, "... *my concern all my life was what people thought about me...*" (P1: 519). He perceived that the mellifluent effects of alcohol quietened the tonic anxiety he was experiencing caused by this way-of-being. Initially, alcohol was effective but, gradually, this changed for the worse:

"P1: ... drinking was fun, and then it was fun with consequences...

R: Yeah.

P1: ... and it just ended up being consequences in the end..." (P1VT: 147-149)

Alcohol became a self-administered medicinal panacea for the stressors created by his way-of-living:

"P1: ... the alcohol was medicating myself to take that fear away." (P1VT: 41)"

The adjectives he uses to express this tonic and phasic "*fear*" include: despair; loneliness; terror; hopelessness; loss; sadness; trepidation; anguish; anxiety and confusion which formed a constant existential background to his life:

"P1: My life was just a constant life of fear, I'd wake up full of fear and I would have enough drink so I could get a couple of hours, but when I woke up the fear was back. I can't tell you what I was frightened of; I was frightened of everything... I was frightened of taking that first drink because I knew what was waiting for me, but I still took that first drink to take away the fear of what may be, or may come and it was always there at the end, always there." (P1: 295-306)

Alcohol allowed him to "*function*", to get through the day, but not appear intoxicated. Metaphorically, he describes this as working from a "*baseline*" or "*level playing field*" which balanced his need for alcohol with the exigencies of quotidian living:

"P1: ... to keep me, er, in that place, er, of the level playing field, the, to a base line that I could work from, er, I could have the energy to get up and go to work which sounds

ridiculous but... if I could have the drink in the morning I could continue to work during the day..." (P1: 187-190)

"*Functioning*", he believed was an act of moderation, even though his consumption had escalated to two litres of vodka, *per diem* (P1: 42):

"P1: ... my drinking was never to oblivion, fall over and go to sleep. It was a case of, it sounds ridiculous, but moderate moderately drinking all day..." (P1: 295-296)

Drinking to oblivion, falling over and sleeping were, for him, the hallmarks of being alcoholic. When comparing himself with this type of behaviour he could view himself as acting in moderation. P1 uses three metaphors to describe his existential frame-of-reference. First, the "*pinball machine*" expresses his daily battle between conforming to his self-image (by exerting emotional and psychological control within his life) and his sense of futility and failure to do so:

"P1: ... my life was like a "pinball machine" where I'd fire up and roll up the table and it'd be Bang! Bang! Bang! From one situation to another, to another and then I would always end up down the hole again. And it's that absolute despair and desperation of a place that took me to...

R: Right.

P1: ... er, just no, hopelessness is probably a better description of that absolute hopelessness, of not having a direction." (P1: 92-98)

Secondly, the "*ball of string*" indicates a cognitive dissonance, whereby his idealised self-image was at variance with his alcoholic-self made public within his immediate environment. He struggled to bring order to that which appeared chaotic:

"P1: ...it was like, you know, it was a ball of string that I couldn't unravel and find a beginning and an end to work to, or to work from, um, if I had a drink that ball of string would just keep there and it would be fine I could just hold that and my, the person that I am, er, I like a beginning and an end and a plan which then just makes, er, a mockery of the fact that I would go and drink and just make an oblivion of all of that..." (P1: 194-198)

His drinking offended his Christian values:

"P1: .....because I'd started drinking then and I felt I wasn't worthy enough to be called a Christian or to be in the House of God anymore." (P1: 143-144)

The crushing weight of his moral culpability is expressed in his third metaphor, the "*black bag*", which is drawn from his felt-sense. The responsibility for his problems, ultimately, rests with him for which alcohol can only provide a temporary relief:

"P1: ... my life was like having a black bin bag over my shoulder and a bottle of vodka in the left hand and every problem that I had I would put in the black bin liner because I couldn't deal with it, and drink the vodka at the same time so this load just continued to get bigger and bigger and bigger. And I was always, I think, the other thing as well that builds upon this I always felt it was my fault, the guilt was all mine..." (P1: 203-207)

On reviewing his narrative description P1 deployed a further metaphor, "*the hammer*", which summarised the futility of his drinking-life when accompanied by self-inflicted pain and suffering:

"P1: It's like hitting your head over, with a hammer to get rid of the headache...." (P1VT: 444)

Seeking help through AA, P1 had been sober for seven weeks. Though not drinking, he faced serious problems: his wife planned to divorce him; his daughter had distanced herself from him; he had a drink-driving conviction; he felt abandoned by his wider family ("*nobody cared*" P1: 349); was suspended from work and faced a return-to-work interview:

"P1: .... up to this point, everything I was thwarted at every... avenue in my life that's how it felt, er, and right up to that point and then as you know, as all this piled on with going, the back to work and it's the straw it broke the camel's back, you know, and the default setting is, is to take away the pain..." (P1: 382-405)

The "*default setting*" represents the level of habituation associated with his drinking. Despite living soberly, little else had changed in his life, so that he felt no positive effects from his AA membership:

"P1: ... being seven weeks sober at that time, things hadn't got any better for me..." (P1: 20)

Herein lay one of his basic fallacies about not drinking. He assumed that, by stopping drinking, his life would automatically improve in many areas of his functioning. His hopes, founded on this expectancy, were to be shattered:

"P1: Yeah. Just become overwhelmed with everything that was happening, um, now, er, I was expecting to stop drinking...

R: Yeah.

P1: ... I'd, well you've been in, you've been, you've got sobriety now you need to crack on....

R: Yeah.

P1: ... and all of a sudden I realised I couldn't...

R: Yeah.

P1: ... I couldn't deal with it or cope with it and as I said I just became over, overwhelmed with all those things coming together and back to type really quickly." (P1VT: 524-532)

Following his return-to-work interview, feeling overwhelmed and unable to cope, but above all that "*... I hadn't moved on..." (P1: 112)* he relapsed:

"P1: ... it was to get rid of the fear and the feelings, to change the way I was thinking, um, I'd completely, when after coming out of this interview, I completely lost faith, er, I'd lost complete direction, had no direction of what to do next or what was next for me. Um, I would say I was at a complete loss (pause) of not knowing what to do, where to turn and it just er, a dreadful experience that all my life I'd planned, worked

for, succeeded and I'd come to this point and I couldn't just see any way forward other than the drink to take away the pain and take away the fear, um, and just a human being without loss, without with loss and without any direction is just a lost soul, a completely lost soul." (P1: 54-61)

He expected alcohol would be a benison; instead he describes his relapse in apocalyptic terms, borrowing a metaphor from AA (1976):

"P1: ...my own personal experience of a relapse was absolute horror, terror, everything that is suggested in, in the "Big Book" the four hideous horsemen, all, all in one." (P1: 1-2)

When asked what he felt to be his key learning-experience within his relapse process, he described his surprise at the speed of his cognitive transformation and return to active-alcoholism:

P1: (Pauses). How quickly you go back to exactly where you were. The period of time is probably milliseconds from taking that first drink, all the, all the old symptoms, fears, er, (pauses) purposes, all the old rules of how you live your life comes straight back (snaps fingers) and how your perception of how things are which have no reality, a lot lot of it, all the stuff I had in my head that was made up in my head and it goes straight back to there in (snaps fingers) just like that, where you've had, had, you've been having good thoughts and straight lines, um, end and start points it all of a sudden "choo!" (snaps fingers) within milliseconds and it's how quickly you go back to an arsehole in the blink of an eye." (P1: 545-553)

In relapsing, he returns to active-alcoholism which lasts for five days, during which time he experiences dire physical and psychological distress: insomnia; suicidal ideation ("*I really wanted to die" P1: 345);* vomiting; and "*guilt and remorse*" (P1: 33):

"P1: ... because I've drunk so much the, er, I started seeing things coming out of the wall, um, and all those things came back....

R: You were hallucinating?

P1: ... oh yeah, yeah, double incontinent, all of it, yeah.

R: Could you say what you were hallucinating?

P1: Er, it was it was like the wallpaper, the pattern was running down the wall, um, snakes, um, spiders, um, er, the bed I was lying in felt like I was at sea and I couldn't put my feet out of the bed because I thought something was going to bite me and then it felt like my heart was coming out of my chest, er, dreadful panic attacks because of all of this going on." (P1: 373-382)

He only stops drinking because he cannot consume any more alcohol. P1 finds it difficult to symbolise the phenomenon of relapse accurately:

"P1: ... um, and for me, there are probably no words that can explain that terror and fear that accompanies, er, the aftermath of a relapse." (P1VT: 473-474)

He cannot justify or make sense of relapse, but believes that it took him to a nadir of experiencing which occasioned a profound spiritual change:

"P1: ... I'd like to say I saw the light but that's, I just saw a way and it was probably resignation, er, and probably acceptance. I'd got to that point where I thought that if I have to leave the family home, I have to do something I could, I thought of being a postman, getting a some sort of council flat and it was to that point where I think I'd been fighting, er, to keep sober whereas I said I won't have a drink, I won't have a drink, I won't have a drink, I definitely won't have a drink, I won't have a drink and I always ended up drinking. Where I got to this point where it was the acceptance and resignation that I could exist and just do something and the fear wouldn't be there and the fear just left me on that day. That even if my wife, my daughter and everybody left me I'd still would be okay as long as I didn't drink and I'd be okay and being okay is good enough.... I know what I had from that day forward that I had some hope … it came from somewhere." (P1: 431-444)

Consequently, he attributes a meaning to his relapse, which he knows to be illogical, but which only makes sense in the light of his continued abstinence-based sobriety. He accepts that he is alcoholic and staying sober is not a matter of willpower. In short, he feels that he had to relapse in order to appreciate the value of sobriety:

"P1: To come fr... and walk away from that I had to accept whether this is right or whether this is wrong, but the only way I could legitimise it in my own thinking was it was something that I had to do.

R: You had to relapse?

P1: I had to relapse to get to where I am. I have to do that now, in hindsight...

R: Right.

P1: I can't, I couldn't have thought about it after being sober for 7-8 weeks to think that what I need to do is go and get drunk again. What I had to do is legit... legitimise that in hindsight to think, well I suppose if that was my end-game that was the thing that I needed to do to find sobriety today to find how bad it was or how bad it could be again, um,....

R: So that kind of proved it to yourself ...?

P1: Yeah, yeah. But that isn't, that isn't good thinking, it's the only way I can make it right in my head that there was a reason why that happened and I had to go through all that pain again, to understand how bad it could be. And that is not good thinking and I accept that, but for me, that's fine and I can deal with it." (P1: 221-235).

P1 describes his relapse as a moment of catharsis, a metaphorical "*end-game*" which, even four years later, he somatically feels:

"P1: ... And to sit here and talk about it now it is quite distressing, but I feel like you know, I don't feel the fear I know the fear, I know where it is.

R: Are you okay to continue?

P1: I'm fine to continue,

R: Okay.

P1: ... it's cathartic, it really is, to get it all out. Because it, it reminds, you know, it's where I come from, it's made me the person I am today..." (P1: 382-388)

Whilst relapse proves to him that he is alcoholic, he remains baffled by his compulsion to drink. His puzzlement is described metaphorically by "*the switch*":

"P1: I didn't have the choice. No, something had switched on or switched it, or switched off and I didn't have the choice, had to go and do it. (Smacks lips) Sssss… it's a difficult one; it's a difficult one to grasp unless you've been there.

R: Yeah.

P1: You know it's like every, every human being that the part, the part thing about being human is having a choice and that choice had been removed. Didn't have a choice, had to." (P1: 614-619)

Being part of AA helps him combat the urges to drink. He gains strength from the "*camaraderie*" of being amongst alcoholics who, like survivors of a shipwreck, possess an intuitive understanding of the phenomenon of being alcoholic:

"P1: AA is a place where I go where there are people that understand the point I made a few moments ago which was that we didn't have a choice, there is nobody but another addict/alcoholic that understands that not having a choice is how we are... there is this camaraderie that is suggested in The Big Book that, er, we are like the, er, people in the ship wreck who find the lifeboat and from the captain to the stowage we are all the same, we've all been through that experience and we've survive... we've all had that same experience..." (P1: 632-646)

On the one hand, the life-experiences he hears within AA are comparable with his own:

"P1: ...every one of those people in in the AA meetings I go is, er, a reflection of myself. I see myself reflected in there ..." (P1: 654-655)

On the other, he recognises that his experiences are subjectively uniquely and may not be generalisable to others:

"P1: ...I can't speak for any oth.. other alcoholics... " (P1: 246)

Relapse also teaches him that recovery is "*fragile*", a word he mentions six times in his narrative (P1: 496, 497, 504, 569, 570 and 637) thus requiring constant maintenance:

"P1: ... the relapse I know for me, for this, for me, I can only talk about me and for me that I know, er, even though it has been a few years that sobriety is a fragile thing and that I need to work at it..." (P1: 503-505)

Consequently, he construes his recovery-life as one which oscillates, minute-by-minute, between recovery and relapse requiring him to manage his life by an idiosyncratic mathematical formula:

"P1: ... I do use the analogy of that, um, I'm 52% sober and 48%, um, in relapse and as long as those two don't come together I'm OK and I'm fine and I can keep my sobriety." (P1: 76-78)

He now believes that his relapse was precipitated because this formula was being misapplied:

"P1: I realise now as the balance that we've talked about 52 to 48 I was probably running at 52%, er, in, um, relapse and 48% in sobriety...

R: Sobriety, right.

P1: ... and then when it came to a decision should I drink or not drink I would always drink.

R: Always?

P1: Always. Always, if that, even now if I, if I came to a point where I thought, "Should I have a drink?" / "Should I not have a drink?" I would always drink." (P1: 112-118)

Relapse also teaches him that recovery is a "*gift*" for which he is an undeserving recipient and which, morally, obliges him to engage with empathic acts of altruism in helping other members of AA who relapse:

"P1: ... part of my recovery is passing that message on to other alcoholics, or other addicts, um, if I didn't have that in my life where I do pass this on, I'm not, probably my recovery wouldn't be as fulfilling...

R: Right.

P1: ... I'd still have recovery but it wouldn't be as big, or full, or rounded than it is and, you know, some of the sad parts are I've tried and helped a lot of people and there is only a few who've come out the other end but at least I've tried." (P1: 622-628)

To relapse yet, subsequently, enjoy sustained-recovery is the hopeful spiritual message of AA:

"P1: ... it is always good to know where we've come from and it's always good to see people in recovery, um, with good recovery at the meetings because we all need proof of life...

R: Uh, hm.

P1: ... we all need proof of life and the AA meeting is, is that." (P1: 657-661)

As the gateway to the "*gift*" of a sober life, relapse has taught him the value of gratitude which he demonstrates on a daily basis:

"P1: ... I'm grateful every day of my life and that I can return to sobriety every day..." (P1VT: 14-15)

10.1.2 **Summary**

P1's experience of relapse remains "*baffling*" (P1VT: 431). He may perceive his return-to-work interview as its final precipitant, but he begins to make sense of his relapse when he realises that his self-image needed to change (he can be "*good enough*" P1: 440) and that alcohol is no longer effective in dealing with negative affect caused through stress. P1 "*legitimises"* (P1: 222) his relapse by theorising that it offered him the "*gift*" (P1: 675) of his current sober and fulfilling way-of-life. He admits the illogicality of suggesting that he needed to repeat the pain of the past and experience further trauma in order for this to happen. But, at this stage of his recovery, this legitimising process keeps him sober. It is made more palatable by his pursuit of moral probity, congruent with the practise of his religious beliefs, involving displays of compassion towards those AA members who struggle with relapse.

10.2 **Participant 2**

P2 is a mature lady, of Irish Catholic descent; married; with a large extended family; who held a responsible position in industry. Her self-image is that of a good wife and loving mother. Independent of mind and spirit her autobiographical summary reveals:

"P2: ... I wasn't argumentative, I wasn't, um, you know (pauses) not a bully but I can, I, I was an always right if you know what I mean, I was one of those people who's always right and, er, and people let me get away with it as well, which was worse. You know, (laughs), because they, they, it was part of my personality, I mean I had a sort of quite a sort of a, um, a strong personality before, alcohol, but it was stronger but fair; alcohol twisted it into strong and, unfair..." (P2: 108-113)

Her drinking began late in life following her father's death and her difficulties in coping with that:

"P2: ...I was only well I was in active addiction for three years I had been pretty low for probably five years be...before that, with my father's illness and everything.... " (P2: 243-245)

After seven months of sustained, abstinence-based recovery, she describes herself as: being well embedded within AA's ideology and practises; regularly attending its meetings; employing coping-strategies which reduce risk, e.g., by maintaining an alcohol-free home and having it removed if brought there; accepting her identity as an alcoholic; being admirably supported by a loving family; and astute to the dangers and threats of external triggers which might precipitate relapse:

"P2: ... I'd been seven months sober and I'd done all of the right things according to AA, um, readings, kept running through the 12-Steps, going to meetings, I, I was pretty secure, felt pretty secure in in my sobriety and, er, you know I didn't have booze in the house, if there was a party or anything people would bring theirs and take it away. I just was extremely careful though for those seven months I had no craving or anything for a drink, um, but I still kept myself safe, I didn't go into any of the aisles in the supermarkets, in fact I used to get, I was Mrs Angry from (names home town), because I used get really mad about them putting cut-price booze at the front of the supermarket entrance and things like that, so everything was going really well, I was really happy, um, never been happier, family were happy..." (P2: 8-16)

Sobriety particularly afforded her an absence of anxiety:

"P2: ...the most thing I enjoyed about not drinking was not having that anxiety in my tummy all the time, you know. Not being able to sleep for anxiety, always thinking I'd missed something or I hadn't done something I should have done..." (P2: 617-619)

Her relapse occurred over Christmas; her ability to entertain her family at home had been a landmark in her recovery to date:

"P2: Yeah, it was an extremely happy time for me that year that was the first Christmas sober...

R: Hm.

P2: ...we had everybody around on Boxing Day and did a buffet and everything like we used to but God, I hadn't been able to for, you know, that's for two years maybe, and struggled through it the first year I think and, um, and I was incredibly happy..." (P2: 232-236)

She genuinely believed (pre-relapse) that she could describe herself as being:

"P2: ... happy, (pauses), er, good with life, (pauses)... thankful, ... grateful, (pauses) loving, (pauses)..." (P2: 36)

As an AA affiliate, she had embraced its teachings by following its 12-Step programme, which brought meaning to her past:

"P2: ... my Step 1 was the best day in my new life, you know, I totally accepted that that's what I was and that was and really that was the answer to all the rubbish that had been going on for the previous three years, um..." (P2: 100-102)

Yet, despite her outward appearance of being sober and socialising with family and friends, she retained the thought:

"P2: ... I used to think to myself that you'll, I'll never be able to enjoy myself again..." (P2: 559-560)

Three days after Boxing Day she was tidying a room when her relapse happened:

"P2: ... there was a glass there when I went, I just happened to go into pick something up and it was, I knew it was coke and I knew it was brandy and coke, because their mother that's what she drinks and without a thought, bearing in mind this had been there for maybe three days, had dust on and everything, without a thought I picked that glass up and drank it...down." (P2: 16-26)

Any expectation that drinking would be pleasurable was shattered. What puzzles her now (as it did then) was the speed at which she changed, metaphorically expressed as "*my head went*" and it being "*catastrophic*":

"P2: ...I wanted to be sick not because of the, of the drink, felt like it didn't feel like anything and it didn't feel warm, it didn't give me a warm feeling, it didn't feel, oh, if I could have vomited that drink up in that next second I would have done, um, because in an instant (pauses), er, my head went that's the only way I can explain it. It was like something catastrophic had happened to me, er, because I'd I'd enjoyed my sobriety and never intended to break it, (now becomes emotional) and the family was happy I was happy and it was catastrophic, it was one drink, so I went out of the study and I found my husband and I told him..." (P2: 26-32)

She tried to induce vomiting; she also became "*hysterical*" as her husband tried to comfort her. To describe this transition between being in sobriety and her change to hysteria she employs the contrasting metaphors of "*absolute fruit*" and "*Mrs Calm*":

"P2: ... he was, he was so upset for me because I was hysterical...

R: Right.

P2: ... I wanted to... I was trying to put my fingers down my throat...

R: Yes.

P2: ...and he stopped me doing it, because he said I don't think that's the problem. (pauses) You know...

R: Right.

P2: ... because I was so hysterical.....

R: Yes.

P2: ...like from being Mrs Calm for so many years to being absolute fruit...

R: Right.

P2: ... you know, I think that frightened him." (P2: 650-661)

The effect of this single drink, which P2 terms her relapse, differs from the collegial understanding of the term amongst her AA friends; this is the uniqueness of her experience. Normally it would be expected that one drink would lead to a protracted period of resumed consumption. When she shares her experience with other AA members, they tend to be dismissive of what she has done:

"P2: ... when I did say it (disclosed about the relapse) people presumed I'd relapsed and I was (pauses) drinking (laughs) and they said, So? Well? Where are you? What have you had? you know, What? and I said I'd had nothing, I've had nothing since..." (P2: 44-47)

But for P2, the mental and emotional trauma of that one drink is no different from a relapse which involves multiple drinks. In fact, from her frame-of-reference, to dismiss the effects of her relapse as being in anyway less than a full-blown relapse is highly dangerous:

"P2: ...some people would just say well that was a little incident and a little thing, slip and you can forget about that, you know and a) I think that's dangerous to ever do it b) I couldn't forget about it. I didn't know why I did it and this really used to be on my mind quite a lot I used to think through the times leading up to, there was nothing dangerous from an AA or, er, an alcohol point of view, there was nothing, um, I couldn't pin-point it, the only thing I could, I can say that I'd come to the conclusion of is I was really happy in my sobriety and I had no doubts (pauses) where I should have had doubts that I would stick to the programme. Once I got that seven months, once I was six months in I thought I'll never do this, I know I'll never drink again....

R: Right.

P2: ... and I think that a tiny bit of complacency came back (pauses) and a tiny bit of "quick see if that does something" (laughs) you know (laughs) "see if that does something to you..."

R: Yeah.

P2: ...you know, that well, you know, will, would I have that one and just walk away? Well I did walk away but I walked away a changed woman within five minutes..." (P2: 169-182)

If there are no external relapse triggers, then the cause must be internal. The effect of her relapse is not merely emotional or psychological but, surprisingly, physically:

"P2: ... people saw a physical change in me, can you believe that?, a physical change, that my body started to go how it was before where it was, round shouldered, crunching in on myself, lowering my head, all the sorts, all the things that I did, when I you know, tightening myself up, um, I physically completely changed and, um, (pauses) I didn't notice that, it was somebody from, um, AA who noticed that and two other friends who noticed that and couldn't understand why because I'd just had this one drink and then nothing else, why did I, why had it affected me so badly in that way but (pauses) it did, (pauses) er, and catastrophic's not a word I use often, but I think that what I thought was this is the end, I thought what I'd done, I was frightened then..." (P2: 50-58)

Even today she can still, somatically, recall her felt-sense of the "*fear*" metaphorically expressed as the "*sicky feeling*", suggesting her disappointment with self; the fear of a narrow escape; and her regret in not choosing another course of action:

"P2: ... I still feel that little, er, twinge in my stomach I can't explain it, it's like a sicky feeling..." (P2: 266-267)

Relapse teaches P2 various lessons. First, though she believed that, "*I'd enjoyed my sobriety and never intended to break it*...." (P2: 30-31) her relapse is no different from active-alcoholism. The "*deep hole*" is a powerful metaphor which accentuates her belief that relapse is nothing more than active addiction:

"P2: ... I went from being happy, (pauses), er, good with life, (pauses).. thankful,... grateful, (pauses) loving (pauses) to, into the same deep hole just from that one drink that I had been in when I was in active addiction, the same." (P2: 35-38)

Secondly, her initial engagement with AA was misdirected as she had tried to learn the AA 12-Step programme as an academic exercise but without the requisite level of personal honesty, whereas, now she repeats this with the help of a more experienced AA member:

"P2: Well, the other thing is there has to be this interaction where you prove, well not prove but where you show complete honesty to another person because I don't think you get that feeling of (pauses) cleansing..." (P2: 341-343)

Thirdly, if she is looking for causality, it may not be a single, external event but an accumulation of different factors:

"P2:...do you know what I mean I'd thought of lots of different things and all could be true and none could be true and all could be all could be tiny contributions." (P2: 241-241)

She construes her relapse as a form of self-testing:

"P2: ... it seemed years since I'd been this happy, you know and, um, (pauses) and that makes it even more weird (laughs). Um, only if in my subconscious I was saying, "Right let's test this happiness!" (P2: 245-247)

It may even have arisen from an inner sense of "*complacency*". This metaphor is her unique analysis of what went wrong and suggests her over-confidence:

"P2: ... and I had no doubts (pauses) where I should have had doubts that I would stick to the programme. Once I got that seven months, once I was six months in I thought I'll never do this, I know I'll never drink again....

R: Right.

P2: ... and I think that a tiny bit of complacency came back (pauses) and a tiny bit of "quick see if that does something" (laughs)..." (P2: 174-179)

It is in her response to relapse that P2 employs a further series of eidetic metaphors which express her acceptance of her condition and the orientation of her life towards that of being in recovery as an alcoholic. First, she labels herself as being a "*recovering alcoholic*":

"P2: ... I've been quite open with people about the fact that I'm an alcohol.., a recovering-alcoholic..." (P2: 742-743)

At the heart of this metaphor is her belief that she must always remain abstinent, that controlled-drinking is never possible for her under any circumstance. Her life as a recovering-alcoholic is a pathway which is developed and reinforced by habituation and in which she has complete faith. This is AA's programme of recovery which she describes as a "way of life":

"P2: ... it's (pauses) just a way of life now, you know ...

R: Hm.

P2: ... just a way of life." (P2: 286-289)

This "*way of life*" requires vigilance (the antithesis of complacency) which she describes as being a "*bit on your guard*" (P2: 408). This process also necessitates a variety of idiosyncratic coping-strategies which she terms her "*safety nets*" (P2: 440) which are developed by practise:

"P2: ... I just have little habits, I just leave drinks on tables, I just have little safety nets.

R: Yes.

P2: ... that help me 'cause I couldn't think of anything worse than picking up a gin and tonic, and downing it and then (pauses) realising it was a gin and tonic..." (P2: 439-443)

Relapse is also a "*gift*":

"P2: ... I'm not saying I wish it had happened but it's been a bit of a gift in a way to absolutely know the horror, the horror you would go back to, um (pause) I wish I hadn't done it..." (P2: 514-516)

The nature of this gift is spiritual (her Catholic faith is once again rejuvenated) accompanied by certain existential benefits which she describes as acts of purification and forgiveness. She feels worthy of this gift by reason of the effort she has expended, post relapse, to restore herself to health:

"P2: ... it was the toughest thing that I ever did personally, on a personal level because I had to be truthful, completely truthful... I felt a bit like I did when you went to confession...

R: Uh, hm.

P2: ... in that you've, um, sort of wiped your slate, um, so (pauses) it was it was absolutely the best thing that happens to me, happened to me, but because I can live my life I have a programme to live by..." (P2: 296-304)

P2 applies the lessons learned from her 12-Step programme and acceptance of her alcoholism to her other illness which, sadly, proved terminal. Not only did relapse eliminate any lingering doubts that she was alcoholic but, paradoxically, provided her with a sense of "*freedom*" (P2: 124) from existential angst. She faces what appears to be an uncertain future with equanimity:

"P2: ... , it's a programme for life and it's helped me with my, um, heart condition, um, accepting that, it's so much easier because I'd already accepted, you know my other, um, life threatening disease (laughs) or terminal illness..." (P2: 276-278)

10.2.1 Summary

P2 interprets her relapse as stemming from her misunderstanding of what it meant for her to be alcoholic and her lack of personal honesty in developing self-awareness. It was a test to see whether she could drink safely or not. A single mouthful of alcohol proved "*catastrophic*". From this experience she is, honestly, able to re-appraise her relationship with alcohol. This necessitates more than abstinence. A life of recovery is a process of "*cleansing*" and developing a "*comfort zone*" (P2: 737-738) which involves eliminating risk. Due to her illness P2 was unable to attend many AA meetings. She was assisted in her recovery primarily by her husband and family.

10.3 Participant 3

Aged sixteen, P3 had a clear, developing and volitional self-image of being "*a drinker*" and organised his life around this construct:

"P3: ... I was a drinker that was it, this was me, this was my, everything, everything was involved in that, that was my personality, that was me, that was my essence...

R: Right.

P3: ... I couldn't stop drinking because everyone would expect me to drink. They don't think that, I wouldn't be me anymore, I'd be somebody else and I was wrapped up in all these, you know, it was, it was something that I grew into when I was 16, it was it was like a part of my evolution and once I'd got that it wasn't you know, in p..., my view at that time, evolution doesn't go backwards and I'd evolved into a drinker and that's the way I would stay and wanting to stop at that point felt foreign, it felt like I was trying to become somebody else." (P3: 115-123)

Not only was this a rôle he assumed others expected him to fulfil, but it satisfied his emotional and psychological needs so that to be sober would feel alien. Living the life of "*a drinker*" he developed a unique, quasi-anthropomorphic and pervasive relationship with alcohol:

"P3: ... There is a bond between the, it is, er, alcoholics, it isn't just about consuming the alcohol, it's it's the whole package, it was my drink of choice, it came in a certain can, that can has a real strong presence and it was just knowing that I I had enough of those and the image of them and and the way they, they were chilled and condensation on the can and and all of these, knowing it was there and what was in it would take away the, that instant, it it wasn't that I had to rip the top of the can and down that, it wasn't that, it wasn't that wasn't what the urges and the feelings were telling me, there was there was something making me feel uncomfortable and the moment I got to that can, that uncomfortableness went, whether that was knowing that my, my drug of choice, my drink of choice was inside that can, maybe that that was the feeling or maybe it was an old friend returning." (P3: 26-35)

Though aware of people's concerns, his desire to drink was paramount. He couches relapse in terms of a futile cycle of being cognisant that he should alter his drinking, but not wishing to stop:

"P3: ... the relapse on the example I just gave you, I suppose started instantly, that period of time (pauses), I was obsessing about it, it had already started, the relapse was there. Did I really want to stop? Probably at that stage, no I didn't, I just felt I had to, maybe because of the wishes of other people, maybe because of circumstances I was in, maybe the fact that I'd hit it that hard before I was feeling that ill I was trying to give my body a bit of a respite, but the relapse as…… I feel had started almost the moment I decided that I was going to try to stop. The relapse was at a point when I had got those drinks but it was inevitable, there was no other option, I was going to open them cans." (P3: 39-45)

Motivating this cycle was his inherent belief that he was able to control his consumption; whereas he never achieved a period of sobriety. This involved a highly subjective process of trying to resist urges to drink which he, graphically, describes as a process of being dragged or pushed towards alcohol as if, metaphorically, being controlled by some "*mysterious force*" (P3: 26) against which he is engaged in a "*battle*":

"P3: ... the process would become an obsession of wanting to drink again and trying to fight that obsession from, for it. If it was a 5 days period, probably 4 of those 5 days would be battling and battling to try and prevent this relapse happening, um, it would get to a point where, partially down to (pauses) not wanting the fight anymore, and partially down to my drinking was such a routine that, that the routine would take over as well and kind of drag me along, that would almost, I would almost drift into it, um, I'd end up buying the drink, not drinking it, in fact, the process of buying the drink would take away some of those obsessions I was feeling over the, over the days and it would, it would suppress the urge to drink briefly for a few hours and then that would build again and I would drink." (P3: 15-23)

He states that, "*I knew that I had let people down, I knew that people wouldn't like it*" (P3: 90-91), but he also knew that, "*I didn't care*" (P3: 93). The driving force behind his drinking was no longer the effects of some "*mysterious force*" but the practical realisation that, "*I can't have the alcohol withdrawn from my body*" (P3: 94-95). He had no fear of experiencing the aversive effects of withdrawal ("*I never saw withdrawal as a as a reason why I wouldn't want to drink again*" P3: 108-109), but without alcohol he believed he could not "*function*" so that relapse became inevitable:

"P3: At that point in my life, that was the only thing that helped me f-function, it, it was everything about me, it was, I couldn't see any other option, there was no option, I needed, I needed that, that was, you know, alcohol had such control over my life, that there wasn't any, (pauses) there just wasn't another option; it had to be." (P3: 50-53)

His belief in a sense of inevitability meant that when he drank, it provided him with a physical sense of well-being:

"P3: And when I drank it, I drank it like it was the last drink on earth, it went down instantly and (pauses) there was, there was a physical relaxation, a physical giving up, whether that was a giving up of what I'd been striving to achieve or whether it was ..., I was back in what I saw at that time as a comfort zone and it would then lead on to the next and to the next and then I would be drunk and once I was drunk, it was a matter of maintaining that and I was back into the turmoil of then to limit the consequences of it affecting other people, pretending I wasn't drunk and trying my best and that became all consuming. I had to drink, but I had to try my best to not be drunk or not to appear drunk and at that point I wasn't drunk enough and that was the cycle. How do I, how do I convince people that I've not drunk but how do I get myself more drunk, because that's what I want to be?" (P3: 78-86)

Active alcoholism, however, was an exhausting struggle which lasted for "*20 years of excessive drinking*" (P3: 98). The moment of catharsis arrived, when he awoke in a police cell having been arrested for drunk-driving and spent two days getting sober:

"P3: the thing that got me sober was being arrested for drink driving and I was, I was put into police custody for, for 2 nights." (P3: 104-105)

He now notices a potential causal nexus between his problems and alcohol. Becoming physically sober, for the first time in twenty years, inaugurated a period of reflection (he had not at this point joined AA) whereby he realised that alcohol was not an "*old friend*" but possessed an "*insidious*" quality. To describe this P3 employs the eidetic metaphor of "*the parasite*":

"P3: ... it (alcohol) convinced me that it was everything, it convinced me that I needed it, it was foreign, it was something that wasn't part of me that's convincing me, convincing me it's part of me and it was feeding off me. The moment I broke the control that alcohol had on me, and and going back to the point that I started recovery,

that period of time gave ... gave me some clarity and gave me a time to realise that (pauses) I could be different without the hold it had over me and something changed and I and I got to know me and I got to know that I didn't evolve into into alcohol, alcohol got hold of me, like a parasite and it was you know, it was insidious it got, it got, it got control of me, it was, it was in control of my body, my thoughts, my actions, everything and that is to answer that question how do I now see relapse, it scares me because I don't want to go back to that. I, I don't fear the, the physical consequences returning to alcohol, I have a fear of losing me.

R: Losing you?

P3: Losing what I am, what I am now and what I am comfortable and happy with." (P3: 145-157)

During his interview, he developed this metaphor, based on something he had heard on the radio, to symbolise a "*parasitic*" illness (P3: 408) which fed on him as its host, manipulating his thoughts and behaviours but out of his awareness:

"P3: ... when that parasite's in us, our inhibitions are lowered and when our inhibitions are lowered we are closer to the relapse..." (P3: 420-421)

Losing his identity of being "*a drinker*" P3 construed recovery and alcoholism as being a matter of restoring the ability to control his thoughts surrounding alcohol and, therefore, increasing his inhibitions. Alcohol may have convinced him that it was necessary, but he was equally amenable to being convinced. He does not need to make sense of relapse and, paradoxically, believes that to do so could even potentiate relapse itself:

"P3: So thinking that I've, thinking perversely, thinking that I've totally understood relapse could lead to relapse." (P3VT: 238-239)

Instead, his reaction to achieving sobriety and breaking the relapse/drinking cycle meant that he joined AA. He now accepts that he is an alcoholic and that recovery takes time, however, to relapse is simple and the risk of doing so is ever-present. His responsibility is both to control his obsessive thinking, but also to avoid contact with alcohol. The need for abstinence is unequivocal:

"P3: ... once that first drink is opened and once that first drink is consumed, (pauses) there is no going back, it's got you again.

R: And keeping you away from that first drink....?

P3: Keeping away, keeping away from that first drink is my responsibility and it's something that I do consciously all the time..." (P3: 176-180)

Relapse precipitates the process of gaining self-awareness, of developing personal responsibly and the need for conscious vigilance against temptation:

"P3: ... I've learned more about my recovery and I've learned more about me, it hasn't changed that I feel I am you know, I can't afford to get complacent about it and complacency I can't, I can't I can't afford it, at one moment I need to be, I need to be on top of my game. One of the advantages of being sober is our minds, our thoughts aren't deadened or numbed by extremely strong drugs as in alcohol. Um, I, I've learned over the years what, what I feel comfortable with and what I don't feel comfortable with and, and in the ways I will manage those..." (P3: 198-204)

The seat of his awareness is AA. This serves as a repository of experiential learning which he trusts and on which he can draw. It teaches him about the practicalities of living in recovery, but also provides potent examples of relapse against which he can compare his own experiences:

"P3: ... once I'd had had assistance in getting sober and realising that I wasn't in it by myself and getting involved in AA, getting, getting involved with other people in recovery, I suppose they become milestones because you you get other areas, you get other other points that you can return to, you know and your recovery feels stronger because you know you're not in it by yourself, you know if there's a problem I can talk to people, I know there's people there, I know that there are people who have been through it, I know from other people's experiences, um,...."

R: And these other people's experiences of relapse or of recovery?

P3: Of both, of both ..." (P3: 212-219)

The value of AA is that it provides him with a workable and trustworthy option to constant drinking:

"P3: ... AA brought to the party, the fact it works, the fact that there were already people who had already done this, the fact that people were telling me the truth, people, I was given another option." (P3: 292-294)

The "*milestones*" of recovery involve getting back to work; rebuilding his relationships with his family and others; his finances and developing interpersonal pro-social skills:

"P3: .... the things I do for other people are different, the way I do things for other people are different. They may not know why, but I do and I can see that that is (pauses) because of my recovery..." (P3: 226-228)

Relapse teaches that recovery is "*fragile*" (P3: 251) and, central to his learning, is the need for coping-strategies which he terms his protective "*barriers*". These can be practical:

"P3: ... I don't go out socially as much as I used to, um, (pauses) I don't put myself in risky situations..." (P3: 336-337)

He may even, as a last resort, tell people that he is alcoholic:

"P3: ... the ultimate one for me is, "Listen I'm a recovering-alcoholic, you give me that and you'll kill me" and I'd be quite happy to use that if that meant me avoiding relapse." (P3: 365-367)

But he is not always sure what he can identify a "*risky situation*" as each requires to be evaluated on its own merits:

"P3: ... I have to ask myself at each event or each different situation, is this right and do I feel comfortable?" (P3: 343-344)

Predominantly, he engages with a subjective process of mindfulness following an exercise (morning and evening) which reminds him of what would happen if he relapsed again and thus keeps him grounded:

"P3: The exercise I do in the morning when I wake up and, you know, everything's alright, I can do the same exercise in the evening and think I've enjoyed today, I've enjoyed doing the things I can and I think I can work that back to one thing that I wouldn't have done any of them if I was drinking." (P3: 231-234)

He is sanguine enough to know that coping-strategies alone will not keep him safe ("... *there will always be one or two barriers down, it's my job to be observant ...*" P3: 267-268) but the primary lesson of relapse is to focus on his identity as a recovering-alcoholic. The risks of forgetting this may lead to "*complacency*" (P3: 200). To describe what he means, he draws on metaphors from games of chance: "*dodged the bullet*" (P3: 390); "*Russian roulette*" (P3: 396); "*playing the odds*" (P3: 401). He learns from relapse that he must, at all costs avoid risk as unrestrained alcoholism is fatal:

"P3: ... nobody I know who has shared their relapse will ever say well, I knew once I'd picked up on the first day I'd get back, it was, it all bets are off, it's all unknown and I, I don't, I won't risk that." (P3: 384-386)

10.3.1 Summary

Having once identified himself as "*a drinker*", P3 views alcoholism as a parasitical and terminal illness, which lessens his fear of alcohol and manipulates him to do things against his will. He construes alcoholism/relapse and recovery in terms of loss-of-control and personal responsibility to avoid occasions which could precipitate relapse. He avers that to relapse is not to fail in recovery, but to choose to believe that life would be better if drinking was acceptable. However, he also states that alcoholism is a "*mysterious force*" which wantonly used him as a play-thing, but with which he colluded. In recovery, P3 has to be aware of this force, but fears understanding or making sense of relapse, as this may smack of hubris. He needs to retain the notion of mystery as this heightens his sense of vigilance and serves as a protection against complacency.

10.4 Participant 4

P4 is married with an adult family and is a grandfather. He helped run the family business. He described himself as one who liked to:

"P4: ... be driving the bus you know I wanted to be in control of my own.... destiny" (P4: 258-260)

His self-image was that of "*Mr Clean, Mr Perfect*" (P4: 11) who struggled to ask for help and distanced himself from other people. For "*twelve years*" (P4: 140) he was a solitary drinker consuming up to a "*bottle and a half*" (P4: 75) of spirits, *per diem*:

"P4: ... I used to get drunk every night, um, I'd be sat at home, um, my wife would go to bed and leave me to it, I'd be sat in front of my computer, um, playing silly games and drinking..." (P4: 90-92)

Having failed to control his drinking he had finally sought professional help, being admitted to a rehabilitation centre where he would not be known:

"P4: ... I tried to do it myself I tried to get sober by reading literature taking advice seeing my Doctor and it didn't work and I knew that, um, I needed some help, so I went to a treatment centre. Um, I wanted, (laughs) I didn't want anybody to know this because, you know, I was Mr Clean, Mr Perfect so I went to somewhere, um, quite some distance from home..." (P4: 8-12)

Getting sober he felt joyous:

"P4: ... I left there and I left feeling like it was my birth..., every day was my birthday, um, I, I felt good, I, I felt good about myself..." (P4: 23-24)

On returning home, *post-partum*, this feeling of celebration persisted:

"P4: ... it was a bit like a honeymoon period, um, (sighs), my self-respect was was fairly high..." (P4: 35-36)

Such feelings of well-being, however, could be misleading as he had been advised when in treatment that he was, metaphorically, like a Christmas cake which had been augmented with alcohol during the year. A therapist had warned:

"P4: ... "That's a bit like an alcoholic, if you were to take that Christmas cake, take all the alcohol out of it, what you're left with is a fruit cake." Um, I didn't I didn't completely appreciate, (laughs) appreciate the truth of it then but I think what she was saying was that all we've done here is, um, taken the alcohol out of your system and given you an opportunity to start afresh." (P4: 29-33)

Despite feelings of well being, he had returned to a troubled family environment:

"P4: ... my relationship with my family was a bit fragile...

R: Yes.

P4: ... because for long enough they'd been worried about what I'd been doing, I'd been lying to them..." (P4: 36-38)

Secondly, he was in the environment where he had drunk, i.e. his home was, metaphorically, his pub:

"P4: .... so I went back to my, I went back to my pub, I went back to my house, um, and in the end of my drinking I'd I'd stopped going to the pub and I did all my drinking at home so when I I left the treatment centre I came back to my pub..." (P4: 42-44)

Emotional problems with his family and the cue-stimulus of being back in his drinking environment combined:

"P4: ... but I, I felt, um, vulnerable, um, I felt that particularly in the evenings, which was the time I did my drinking..." (P4: 41-42)

Evenings served as a temporal cue or stimulus to renewed thoughts of consumption, based on his historic practise. There was also the unresolved strain within his family relationships which he had yet to address as, due to his drinking:

"P4: ... my relationship with my wife had become, um, dysfunctional, the kids weren't really talking to me, um, my daughter wouldn't let me have, um, unsupervised access to my grand-daughter who was about 7 at the time..." (P4: 93-95)

He uses the word "*dysfunctional*" to describe the fact that his wife had become co-dependent in trying to protect him from the consequences of his drinking. When, *post-partum*, he had returned home, she wanted to help him but he dismissed her assistance, partly because he wanted to protect her and partly because he would brook no interference in his recovery. Even so, being responsible in some way for his wife's mental state, had added to his emotional and psychological burdens:

"P4: ... I'd sort of, sort of cut my wife out of this recovery process ... she said well what's what can I do to help you and I said, um, nothing, um, because I knew that she'd become, um, co-dependent...

R: Hm.

P4: ... my behaviour had affected the way she behaved, she tried to protect me ... I said to her you don't need to do anything, I said that, um, I can get all the help I want for nothing, er, thousands of people out there will be willing to help me...

R: Hm.

P4: ... who've all been through the same experience as I have and some who've had experiences that I haven't had and don't want to have, um, and ... whilst I did it for the right reasons, I did it so my wife didn't think she would have some sort of responsibility for my sobriety...

R: No.

P4: ... anyhow, I, I think at the time she found it, um, difficult to cope with, so much so that in fact within a month she was receiving in-patient care for, for at her mental state, um..." (P4: 215-234)

Thoughts of relapse were emerging. He began to question the seriousness of his drinking which, in turn, called into doubt whether the problems which he faced were as serious as he had been lead to believe when in treatment:

"P4: ... and I started thinking about the unmanageability of my life and I thought well it can't have been that unmanageable? You know, I've been running a successful business, I'd never been to prison, I'd never been arrested, my wife left me but she came back very quickly, the kids were again talking to me, um, I wasn't in financial trouble so all these things were sort of sitting in the back of my mind but I, I, I didn't tell anybody what I was thinking 'cos, I suppose, um, I knew what they would say to me if I said to someone in AA or someone at the treatment centre, look this is what I'm thinking I knew what they'd tell and I didn't want to hear it..." (P4: 57-63)

From his frame-of-reference these achievements were beyond the capabilities of an alcoholic which caused him to question the validity of applying this label to himself. However, he felt "*ill at ease and out of sorts*" (P4: 46). Intellectually, he struggled with the concept of having to remain abstinent for the rest of his life:

"P4: ... I found it hard to picture, um, a lifetime without drink..." (P4: 161)

He describes this process of thinking about the future as "*projecting*", a form of rumination which was attended by self-doubt and a lowering of his mood. He tried to distract himself by undertaking building projects for his family:

"P4: ... I was projecting, I was projecting and and that projection meant that I was restless, um, I found it difficult to sit down and relax, I always had to do something. Um, I started a building project up at my son's house, I was there from morning till night knocking things down and building things up again, um, making things with wood and taking them apart again, so I was hyperactive, um, but when evening came, um, I found that the only activity that I had any recent recollection of was drinking...

R: Right.

P4: ... in the evening and that's, that was that that feeling of unease that I'd I'd when I mentioned I felt vulnerable, um, and I also, I also felt that you know I wasn't, I wasn't convinced that the old days wouldn't come back and that I, I wouldn't be able to to keep this up, um, but which turned out to be true." (P4: 168-178)

He took some positive steps to make his home alcohol-free:

"P4: ... we agreed that there wouldn't be any alcohol in the house. Er, we changed the glasses so all the glasses that I used to use to drink my whisky, um, went, um, there,

there, there was some sort of cosmetic stuff like that but but I didn't feel at ease, I was constantly on my toes and whilst I know it wasn't withdrawal it, it, it was certainly the compulsion to drink was still there. The, the old, um, the mental, um, the idea that a drink will fix you and relax you and make you feel comfortable, um, was still there." (P4: 148-153)

He attended AA which helped:

"P4: ... I found a couple of AA meetings that I particularly enjoyed and I used to go to those each week, er, Monday and a Friday, um, and that that was OK but there were times when I felt ill at ease or out of sorts and the way that, um, helped me was just to on the spur of the moment have a look around at a list of local meetings and decide to go to an AA meeting...

R: Uh, hm.

P4: ... and the wonderful thing about it was I always came home feeling better than I did when I left. Anyway, this went on for 3 or 4 months...." (P4: 44-51)

It was only after his relapse, that he came to appreciate the advice he was given. First that recovery is "*learning to live, um, sober, learning to to have a life*" (P4: 105) and secondly, that this entails finding "*a way of life that is acceptable to you, without, without alcohol*" (P4: 107).

Four months after treatment, he relapsed when his wife went away for a few days and he was alone. For two weeks, prior to her departure, he entertained thoughts of drinking:

"P4: ... some of my self-esteem slipped away ... over that, the two week period of, er, gestation if you will, um, on the face of it nothing happened but but it was at the back of my mind, I then I then had a drink..." (P4: 185-190).

His drinking lasted two days when he was discovered by his son, who told the treatment centre and P4's wife ("*my son grassed me up*" P4: 200). P4 did not experience harmful physical side effects but felt "*ashamed*" (P4: 197). He was also aware that some process was taking effect whereby he might not be able to stop drinking:

"P4: ... but I'd made my mind up that given another week I'd be back to a bottle and half a day because, you know, it it would it would just progress as quickly as that..." (P4: 74-76)

Although he returned to AA he was reluctant to engage with the process of recovery. His stumbling block was the absence of the dispositional quality of "*humility*", ("…*there's a little word called, um, humility which I hadn't discovered*" P4: 317) due to his self-image which prevented him from being honest with his thoughts and feelings:

"P4: ... I'd always thought I knew best... I was in charge and I, I made the decisions, um, so I wasn't, um, I wasn't ready to open up and admit to someone else that I didn't know all the answers." (P4: 111-117)

P4 attributes this reluctance to his "*ego*" (P4: 323) an overweening sense of self-importance, but also a "*fear of never being able to drink again..."* (P4: 159). Because of his reluctance to engage with AA he found fault with its teachings, especially the mantra of living one-day-at-a-time:

"P4: ... When I first heard it, um, I thought that's for (pauses) half wits (pauses)...

R: Right.

P4: ... that's for people who've got no mind no brain no intellect, um, everybody has to be able to plan their lives and plan ahead and and to try and keep that in a day is nonsense." (P4: 163-167)

Over a protracted period of time (which involves several years) P4 perceived relapse in four ways. First, it was not a discrete incident but involved a process:

"P4: ... the actual act of picking up the drink...

R: Yeah.

P4: ... um, I see as just one part of the relapse...

R: Right.

P4: the relapse for me started at the time I decided to have a drink when my wife went away.

R: Yeah.

P4: I think I'd relapsed then effectively." (P4: 119-126)

Secondly, relapse was a test to see whether he was truly alcoholic:

"P4: ... Um. At that point I didn't understand why, I think it was it was a matter of, I think I'll test myself, see if a really am an alkie..." (P4: 56-57)

Thirdly, from his frame-of-reference, relapses were premeditated:

"P4: ... the most important lessons are that, that um,... relapse kills, drinking kills, relapse, slip, call it what you will, it's and in my experience they have always,(hits table with hand), always (hits table again) been planned." (P4: 445-447)

Fourthly, his relapse was part of his phenomenological experience of being alcoholic:

"P4: ... in order to get a true (pause), um, view of why I relapsed, um, it was my journey that I had to, to, to learn the whole programme..." (P4: 281-282)

Therefore, he can aver with certainty:

P4: I'm not cured. Yeah, I'm in remission, um, I'm in recovery, um, and I'm happy about that and I, um, in some ways I'm happy that I relapsed in the fashion that I did, I mean, I'm not happy that I relapsed, but, but I think it's probably necessary for me to sit down and have a hard look at myself, um. The relapse, I, I see many, many people relapse over, you know, over time and a lot of them never get back and some, some, some die, some get into dire trouble. I was lucky, I didn't..." (P4: 388-396)

P4's response to relapse was that he engaged with AA more fully, but that this process took a long time. For him to understand the need to live in the moment took him "*seven months*" (P4: 443). It took him "*two years*" to begin, as he felt, to be honest with others (P4: 262). Recovery becomes an on-going process of personal/spiritual development which cannot be hurried.

"All I can do is try and make sense of relapse and I can't. It happened to me and the best I can take out of that is that it taught me that I had to change along spiritual lines. The treatment I had got me sober, but it did not change me. That has taken a very long time and is still happening." (P4: Letter: 67-70)

But he was also painfully aware that the damage he had done to his family was equally lasting. He cites, for example, his daughter forbidding him access to his granddaughter because she believed, mistakenly, that he was drinking again; this event took place "*three years*" after he got sober (P4: 371).

Whilst P4 responds to his life in recovery by engaging with practical coping-strategies which necessitate avoiding alcohol or "*wet places*" such as pubs or "*the booze aisle at supermarkets*" (P4: 428), relapse has also taught him the need to develop predispositional qualities of personality. These may be founded on the need for "*humility*" which lead to the acceptance of his alcoholism, but go deeper than that. His self-image now means that he views relational attitudes towards other people as important and describes himself as:

"P4: ... I'm respectful, I'm honest, um, (sighs, pauses) and that I, that I am, I'm disciplined, yeah...

R: Yeah.

P4: ... persistent, disciplined and consistent...." (P4: 479-482)

He also perceives that relapse has simplified his life as, though he may not understand alcoholism and relapse, he senses a greater congruence within himself:

"P4: ... my life's so simple, it really is simple, I started off by saying I was vulnerable because my head was so complicated, there were so many things going round in my head, the old thinking, the old thinking was still there, the old character traits, the old obsessions were all there, they're not there now. Or they're not at the stage where I can't control them, or I don't understand them, and I can I can take a different slant." (P4: 484-488)

Relapse has taught him that he has an option to choose a pro-social way of living.

10.4.1 Summary

Relapse is not a discrete moment within P4's move towards recovery, but forms part of his long-term process of personal change and learning to live soberly. A relapse is a planned event of which consumption forms only a part. There may be environmental and emotional states which help precipitate thoughts of drinking, so that the commitment to drink happens long before it is physically ingested. Relapse attenuation comes from developing dispositional qualities, especially the virtue of humility, learned through AA's 12-Step programme, which militate against thoughts of self-importance or "*ego*". Though important (being potentially fatal) relapse is but one necessary component towards the acceptance of total abstinence and personal, spiritual change.

10.5 Participant 5

P5 is a mature lady; previously divorced; living with her long-term partner. She has a daughter and granddaughter. Her childhood was dominated by her sister's mental health problems which demanded the totality of her parent's love, care and attention. Consequently, she filled the vacuum of emotional neglect by taking comfort in alcohol:

"P5: ... living with my sister who was (names illness) wasn't easy and not getting, always being told by my mum when I wanted something sh, sh, er, you'll upset (states sister's name), don't do this you'll upset (states sister's name), never, never quite getting my needs met, alcohol filled a hole in, in that space, um, and that went on, I mean I, I love my sister dearly ,um, but, but there was always throughout my mother's, my parents' life really the knowledge that, that she was their priority because she was the sick one..." (P5: 261-266)

From an early age, she learned to fulfil her family rôle as "*the good girl*" (P5: 294). This introjected condition of worth meant that she won the approbation of her parents (and others) but only by suppressing her needs; being undemanding; and content to be ignored and isolated from those emotional comforts which she saw given to her sister. Due to this neglect, a complex range of destructive emotional and psychological

feelings developed within her, directed towards her family and especially her anger towards her sister, which exacerbated feelings of guilt:

"P5: ... there was a lot of anger and I was unable to express about that, because how could you express anger against somebody who was sick and so, er, I am, I'm convinced that a lot of these unresolved at that stage difficulties I had, with my relationship with my feelings about my sister, all sort of accumulated..." (P5: 267-270)

Her early years reinforced this rôle of needing to win the approval of others, or conforming to what was expected of her:

"P5: Prior to the relapse yes, I was trying to please...

R: You were pleasing other people?

P5: ... I was pleasing other people... " (P5VT: 413-415).

She first consumed alcohol in her mid-twenties, by which time she described herself, metaphorically, as a "*little country bumpkin*" suggesting a nervous, unworldly person; lacking in confidence and self-esteem ("*out of my depth*" P5: 60-61); yet trying to present the incongruent image of a social sophisticate:

"P5: ... I was very, very nervous because I was this little country bumpkin, pretending, pretending to be a superior, um, grown up woman you know, I'd divorced, been married, divorced felt that I was a woman of the world...." (P5: 52-54)

Though disliking the taste of alcohol, ("*... I hated the taste of it with with a passion..."* P5: 58), her drinking "*escalated*" (P5: 59) as she found that alcohol not only gave her "*confidence*" (P5: 257) to be a "*woman of the world*", but helped fulfil her idealised and introjected rôle of the "*good girl*":

"P5: ... it, um, er, made me become in my head the person that I thought my parents had wanted to be..." (P5: 260-261)

Conversely, her anxiety increased as she needed to keep her drinking secret so that, in time, she was drinking alone, feeling isolated and ashamed:

"R: So something that starts (clears throat) pardon me, socially, in a sophisticated way becomes over time something....?

P5: That I was doing on my own...

R: That you were doing on your own...

P5: ... isolated and ashamed." (P5: 62-66)

Drinking was a clandestine affair:

"P5: ... my drinking was always done secretly, my, I was always a secret drinker, I kept booze in the garage, and would sneak in there or say I was going out for a cycle ride and I'd drink there..." (P5: 17-19)

She was now drinking around-the-clock and trying, though failing, to keep this hidden from her partner and friends:

"P5: Oh, amazing problems, um, er, yes, looking back and and when I remembered now, um, we didn't have a relationship then, er, I would be, er, drinking, er, twenty four seven. Um, and getting up in the middle of the night even and I'm meaning twenty four seven, um, so (sighs), I, I fooled myself but I wasn't kidding anybody, I fooled myself that I was getting away with it because I felt incredibly lucid and very, incredibly together, er, and I, I didn't kind of see it as a problem at all, I, it just became part of my life..." (P5: 79-84)

She was shocked, therefore, when her partner gave her an ultimatum to change:

"P5: ... my partner, er, had said unless I did something he would leave me and that really, really hit me in the stomach. I was so surprised that he'd actually considered leaving me, um, and he just burst into tears and said he couldn't carry on living with me any longer under these circumstances and so that's when I made the decision that I had to do something about it." (P5: 74-77)

She joined AA and got sober (she does not state how), the effects of which she found transformative:

"P5: ... being sober (laughs), um, er, the benefits, my appetite came back I don't think I was eating very much at all, um, in my, er, drinking days, um, er, I could read books, I could read, I could cook, I could eat, um, I could, I, my memory came back although it's going now, I can only blame my 70's for that (laughs), um, it was, um, it was like a re-birth really, I can only say that it changed my life..." (P5: 70-74)

Yet it was from this position which she relapsed two years later. Acknowledging that, "... *things aren't going too well at home*..." (P5: 27), she was unable to identify any causal triggers, situations or emotional states that potentiated relapse. She was aware that her social life involved being amongst people who drank and that:

"P5: ... not drinking and being with a whole load of people who are drinking is a very difficult place to be unless you know how to handle it..." (P5: 134-135)

In hindsight, her relapse (of which alcohol consumption was but an outward physical manifestation) derived from a lifetime of unresolved intra-personal stressors:

"P5: Oh it was nothing to do with drinking really, the drink was the end of the passageway...

R: Yeah.

P5: ... it was the whole build up...

R: Yeah.

P5: ... the emotional build up and the, er, er, the past and everything else that led towards that." (P5: 35-39)

Her relapse was planned:

"P5: ... It's planned, it's, it's, it's thought about and it's planned and it's, it's you're ready to go and you're gonna do it and it's not going to matter and just one won't hurt and it's there in your head." (P5VT: 46-48)

She was going on a train journey which provided her with her opportunity to drink alone:

"P5: ... I should be on the train and I should be on my own and, um, whereas, er, it just seemed an ideal opportunity to isolate myself from the whole world and have a good time...

R: Hm.

P5: ... go back to the drink that I loved." (P5: 28-32)

The physical act of drinking was achieved quite quickly, though the immediate attempt to keep this secret failed:

"P5: I then of course had to hide it from my daughter in (names place) which I thought I had done successfully but of course I had completely failed, um, and, er, (pauses) she challenged me and I said it was just a "one-off", I was just feeling depressed, "You don't need to worry about anything" and ... I got away with it, um, in that way and, um, (states name of partner) at home never knew about that relapse." (P5: 34-41)

P5 reveals a curious countervailance of existential thought which surrounds her relapse. On the one hand, she is sober and enjoying the benefits which that brings, but she also harbours thoughts of "*love*" for alcohol (P5: 32), with the remembrance of where that relationship took her. On the other hand, relapse represents the "*good times*" (P5: 242) and a chance to "*isolate*" (P5: 29) from others and return to alcohol as if to a *quasi* secret lover. Her ambivalence between these two states is expressed by two contrasting reactions to her relapse. First, that of horror, confusion, shame and self-loathing:

"P5: ... It was horrendous to start with, it was, it was something I didn't want to do, it was something I didn't think I would ever do, I thought I was sticking to the programme. I felt incredibly ashamed, a complete failure and went back to the... all the inadequacies that I had when I was drinking. So it was a real, my thoughts were really muddled and confused and I, why wasn't I good enough to do this, why, why couldn't, why couldn't I just put the drink down, why had this hit me at this time?" (P5: 8-14)

Secondly, her belief that she could handle drinking and that no-one need know of her relapse:

"P5: ... part of it was, er, I can just have one drink because I know I'm sober and I know I can handle it, and I, I know I don't have to have it, but, (whispers) I can just have a secret drink." (P5: 92-94)

Relapse, however, briefly releases another configuration of self, the "*naughty*" girl (P5: 215) who is no longer repressed, so that drinking becomes an act of rebellion:

"R: So having made that decision that I can that I can have one secret drink and you've planned it to do it on the train, what were the feelings like?

P5: Yee, hee! (laughs)

R: Laughs with P5.

P5: Oooh! (laughs) Um, er, that was the initial, um, and but but afterwards the remorse was what have I done, what am I doing, um, (voice goes very quiet) er, and then you go back to God but it was fun. And it was the two sides of me, it was like you know, almost being schizophrenic it was the side of me which desperately wanted not to drink and the side that was actually gagging for it I mean but and they were sort of battling with each other in my head all the time, so it was, it was, (pause) it was ,um, a difficult time, it trying to (pause) I was ashamed with myself basically, I was, I, I wasn't good enough, I was useless, I was hopeless to do this, um...." (P5: 106-116)

Relapse offers her a chance for "*freedom*" (P5: 236), the feeling of being "*carefree*" (P5: 299) and the chance to be defiant "*... bugger the lot of them!"* (P5: 234). Through AA, which represents an empathic, non-critical family unit which she has longed to experience, P5 came to an awareness of a lost child within her:

"P5: ... it's a feeling of belonging it's the, er, within, within AA, it's a feeling of knowing that, that, er, there are people there who understand rather than my family used to say, or everybody used to say or imply that I was weak will willed in my alcoholism and that you know, er, why on earth can't you stop, or why why on earth would you want to start again, um, you you stopped, you're not drinking any more, um, fine, end of story, when it is a a daily programme and will be my daily programme of keeping sober

for the rest of my life, I hadn't got hold of that, I think when I had the relapse." (P5: 177-183)

Though AA is comprised of people from different backgrounds, she believes that they share a common goal of recovery, so that she fits in with their commonality of purpose:

"P5: ... everyone in AA is so different, we come from different works , um, paths in our lives we're different kind of people, we have our different histories, that have brought us to the stage where we drink and the decision not to drink, again is then again different, the only thing that binds us together, is, is in recovery....

R: Yeah. Okay.

P5: ... and that's different for everybody." (P5VT: 21-26)

Within AA she received a satisfactory explanation of her alcoholism which both matched her experiences and provided a potential means of living with it:

"P5: ... I have a disease and that I have to learn how to look at, I can't solve everything, er, I have to have humility and seek help, get help be with people who can help me through the times that are going to tempt me or through the through the whole process of living a sober life. It's to be with like-minded people who understand me..." (P5: 171-174)

The "*disease*" metaphor, derived from AA, appears to pose no conceptual difficulties for her. But AA helps quieten the mental debate between her conflicting images of the "*good*" and "*naughty girl*":

"P5: Ah, I don't think you can just silence it unless you do something else, I don't think it will go away unless you actually admit that you need help and get that relevant help...

R: Yeah.

P5: ... so, er, no if I hadn't then gone to AA and gone to meet alcoholics and actually really accepted that I was an alcoholic, I don't think I would have been able to stop

without having, um, a programme or something to work with to enable me to do it. I couldn't have done it on my own..." (P5: 122-127)

She believes that relapse indicates that, as an alcoholic, the potential for future relapse is ever-present and so she applies clear avoidant coping-strategies, within her lifestyle, to minimise the risks of temptation. Having identified that certain situations (rail or plane journeys) pose especial threats, she may "*speak to myself very firmly*" or sit far away from where alcohol is located:

"P5: ... even to this day when I get on a train or get on an aeroplane I say to the air hostess or I have speak to myself very firmly and sit the far away from the restaurant on the train as possible, I have to be very firm with myself, I know that, er, it's only just at the end of my hand even now and I think always being not afraid, afraid of the relapse but always being aware that I am capable of it so that that relapse taught me something in terms of my sobriety now." (P5: 137-141)

She is not averse to telling people immediately upon meeting them that she is alcoholic:

"P5:... alcoholics deal with this issue in different ways, I will wherever I go, if I feel there is any risk of me getting into a dangerous situation I will come clean straight away and I will say to the person that I am with, I am an alcoholic, um, er, and I will not be drinking and please respect that, by not offering me a drink and it works for me, now other people might find different ways of, of in different situations but that is one that works for me." (P5: 353-358)

Her relapse indicated that by relaxing her vigilance surrounding her attitudes towards alcohol she increased her potential to drink:

"P5: Um (pauses) I had become complacent, um, and thought I was, I was never gonna drink again and that, er, everything was going to be, that was absolutely fine and I think it (pauses)...

R: This is when you'd stopped drinking...?

P5: ... Yeah and the relapse ss, ss, scared the shit out of me...

R: So you felt confident when you stopped drinking?

P5: ... Yes, I had become complacent I think about, my I, I, I had I had been finding it relatively easy um, not to drink, I had, I had thought it was not a problem for me anymore...

R: Yeah.

P5: ... I had forgotten the bogey man on my shoulder, I had forgotten that that at some point something might trigger me off and make me want to do it again..." (P5: 143-152)

Metaphorically "*the bogey man*" confirms AA's aphorism, "*once an alcoholic always an alcoholic*" (AA, 1976: 33). Relapse serves as both the constant reminder of what her life can become, should she be tempted to drink, but also as her motivation for future sobriety:

"P5: ... I'm happy in my recovery, I'm carefree in my recovery, I love my recovery, why would I want to go back now? I think I have to have a picture not only of how awful it was in my head, but how good it is now in my head so that I've got those two, er, two things as a as a thing to keep there...

R: Yeah.

P5: ... rather than just having the awfulness of, of what to relapse would be like, I need to have the the amazing life that I have now in, in my head." (P5: 315-320)

10.5.1 Summary

P5 relapses after two years of sobriety, which she explains not in terms of depression or serious negative affect, but because she had failed to address a repressed side to her nature, caused through years of conforming to the expectations of her parents and significant people in her life. The temptation to drink, which she characterises as the "*bogey man*", awakens a rebellious, alter ego, the "*naughty girl*". This aspect of her personality, though angry with her sister for the attention she received as a child, has no clear emotional boundaries. AA provides P5 with a loving, supportive and non-

judgemental family as well as an abstinence-based recovery programme for living, which keeps this riskier aspect of her personality under control.

10.6 Participant 6

P6 is a middle-aged, married, family man. He gradually developed a rationale for his daily drinking which construed it as being a temporal marker between the exigencies of everyday living and, subsequently, moving into a period of relaxation on returning home each evening:

"P6: ... I always drank I believe to, um, to mark the passage from working, I've often worked at stressful levels and I liked to have a a drink to mark the passage from work to when I stopped and ... I would stop working and I would then be relaxing and drinking and the two things were the same so I, I believe that's the basis of, er, why I drank, well apart from the fact that I drank because I liked the effect. But it came about because a lot of it because it was this cut off between work, um, and relaxation, er, and I wanted that a feeling of relaxation and, um, and euphoria I suppose." (P6: 29-35)

Alcohol served as: a ritualised reward; an effective relaxant; and a pleasurable experience ("*euphoria*"). However, through habitation, the salience of alcohol increased:

"P6: ... I can remember 20 years ago drinking in an evening which is when I drank by and large um, I would drink 6 to 8 cans of Stella, strong lager, er, I remember that clearly ... and then that became, um, vodka and I would be drinking at the end just short of a litre of vodka a night...

R: Right.

P6: ... the pattern most nights would be I would start about 5 o'clock and, er, I would have had my vodka by 9pm, probably go to bed." (P6: 50-56)

He now believes, alcohol decreased his ability to exercise freedom-of-choice as to whether to stop drinking or not, because he had become mentally obsessed with alcohol and needed to drink. In other words, he had become "*addicted*" to alcohol:

"P6: ... I believe, somebody who is addicted, who has no choice no personal choice over, over it is one way of looking at it and the wider way that I've come to look at it, is that alcohol was a problem for me, it caused problems in my life that I can now see more clearly but I, I was addicted, I was obsessed, what, er,..... No I will answer your question directly, what I mean by being an alcoholic was I was obsessed with alcohol, I had to have a drink every day and I did for 20 years before I stopped ...." (P6: 173-178)

The phenomenon of his obsession took the form of an internal dialogue, whereby an egodystonic, maladaptive inner-voice perpetuated his need for alcohol and, eventually, extending this need to a core-belief that his drinking was a mandatory, quotidian pursuit:

"P6: ... in terms of obsession, the obsession said to me you have to, you have to drink every day and if you don't you will sit there miserable until you do..." (P6: 371-372)

He describes his obsession by the metaphor of "*craving*" (P6: 373), or inability to stop drinking, which he avoided by daily drinking, *"... I never gave it a chance, because I had a drink every day, I always gave in (laughs)..."* (P6: 373-374). He labelled his process by the additional metaphor of being a "*functioning alcoholic*":

"P6: ... so yeah I could accept that I was an alcoholic but and and this is why I liked the idea of being a "functioning alcoholic", I loved the idea of being a "functioning alcoholic" because it combined the two things that were most important, the one I functioned and that two that I could continue to drink (laughs)." (P6: 152-155)

This metaphorical label fulfilled three purposes. First, it formalised his behaviour. He believes this to be a typical process of alcoholics who seek to create an environment in which they are permitted to drink:

"P6: ... it was easier for me to admit that I was an alcoholic to the people that I would admit it to like my wife, because it was to me it was self-evident I, you know drinking what I did, I just knew that people would think that I was an alcoholic, so it was easier for me to actually admit it and then move on from there and I believed that, that, that was part of it. It was more realistic, yes I'm an alcoholic but you know, come on leave me alone, er, I'm not doing any harm so leave me alone (clears throat), um, that was part of it and partly again looking back I think you, you will, I think the alcoholic will

invent any explanations that seem convenient at the time as long as the one, as long you are allowed to continue to drink..." (P6: 145-152)

Secondly, it provided a protective barrier against those who wished him to change, by adhering to the illusion that he could exercise personal autonomy to stop should he choose:

"P6: .., but I considered myself to be particularly functioning ... (I) was under the illusion that I that I controlled my drinking (laughs). It seems farcical in, in retrospect but I had a clear idea that I controlled it because I didn't have a drink until 5 o'clock or half past four or whatever it was in the day (laughs) because I controlled that I thought that I was just using it as a release at the end of the day, but in retrospect I wasn't. I, it, it had me by the scruff of the neck and now I can see that but I couldn't at the time, I thought that, I knew I had a problem but I controlled it as much as it controlled me, but I didn't." (P6: 105-111)

Thirdly, not drinking before 5.00 pm evidenced, therefore, that he maintained self-control; this was his *comparator (*see Chapter 2*)*. His consumption, however, triggered a secondary process or "*craving*" which meant that his willpower failed:

"P6: ... I think it switches to a different process which is I must, I must now maintain this, I mean I've got this state and now my, my I'm bothered about maintaining the feeling and I, I remember chasing that feeling sometimes some evenings successfully, and some evenings unsuccessfully it just didn't work perhaps towards the end in, in quite the way I wanted. (Pauses). And and also, I, I have no other way, I think it is different thing I have no other way of explaining why at the end of the party I just wouldn't want to stop, er, it's typical of many alcoholics and I remember it, I didn't want to go home, I didn't want to stop, I didn't want to stop drinking." (P6: 381-387)

He also became aware that his relapse differed from other alcoholics as he did not have a period of cessation before resuming consumption:

"P6: ... in my particular case I didn't completely stop, and that's the difference ..." (P6: 348)

Within AA there may exist a phenomenon vicariously termed *alcoholism,* but he believes that the description of its symptomatology manifests itself differently amongst its members:

"P6: ... The way I think of it is that if you were to characterise alcoholism as having 20 symptoms it may have a 1,000 I don't know but if you were to say it had 20, most of us will have 15 some will have 10 some will have 20, but you're still an alcoholic..." (P6: 360-363)

Two years before becoming sober he undertook, with his GP, an NHS harm-reduction programme aimed at controlling his intake:

"P6: ... I did cut back I eventually just went straight, went back to where I was before and was drinking at the same levels." (P6: 8-9)

Keeping a drinking "*log*" (P6: 11) and engaging in "*exercise*" (P6: 13), he scuppered his chances of success because his belief-system surrounding alcohol had not changed. He continued to drink a volume of alcohol to gain a metaphorical "*effect*" or "*kick*" which typified, for him, alcoholic-drinking:

"P6: ... the truth is I always kept back (pauses) a certain amount, er, I, I probably cut to a quarter of what I drank, but I always kept back that quarter and I drank it in truth in an alcoholic way, because I'd pretty much drank it all at once...

R: Okay.

P6: ... so that I had the effect from that quarter of the volume, I still had the kick I wanted from it." (P6: 14-18)

The "*effect*" metaphor appears to be an elusive "*state*" of well-being which only alcohol provided and which motivated him to drink:

"P6: ... I mean I've got this state and now my, my I'm bothered about maintaining the feeling and I, I remember chasing that feeling sometimes some evenings successfully, and some evenings unsuccessfully it just didn't work perhaps towards the end in, in quite the way I wanted." (P6: 383-384)

As a "*functioning alcoholic*" he, deliberately, perpetuated his illusion of self-control by the phenomenological metaphor of *denial*. *Denial* permits him to distort or deny to his awareness the true affects of his drinking on himself and others. Even at the end of his active-alcoholism, when for months he had become increasingly sick, he persisted in denying any causal nexus between alcohol and his physical ills:

"P6: ... right at the last, even during my last interview with the GP before I stopped I thought that I had more than one thing wrong with me, I thought that I had a stomach condition and I thought that I, yes, I was an alcoholic and I drank too much but I thought I had this other stomach condition and right up to the very end I said to him, "So there are two things wrong with me" and he said "No, (laughs) there's only one thing wrong with you" and so even at that stage I was, I was in denial, partly thinking that I was being very honest about it and understanding it but partly I could see in retrospect I didn't understand it at all, so I, I realised then that this the business of, er, you, you know, and I was also advised with subsequent treatment that, er, I had to stop..." (P6: 127-134)

P6 characterises his relapse as the discrete period when, with professional help, he attempted but failed to control his consumption. He defines alcoholism and being alcoholic, metaphorically termed the "*alcoholic way*", as a phenomenon involving: the increasing salience of alcohol (his obsession); his inability to control his intake (craving); his trust in his own self-efficacy to stop (denial); and drinking for the purpose of an expectant (and needed) effect or "*kick*" which only alcohol provided:

"P6: I (clears throat), I now look back at the, that attempt to stop and the subsequent relapse as inevitable, I don't think there was any other, for me, I don't think there was any ever going to be any other outcome because I now believe that I was an alc… I was clearly an alcoholic at that point, I believe that cutting down and controlling drinking is an option that is open to drinkers in the early stages of an alcohol problem but becomes, (pauses) well, er, it's, it's just not an option once you have become clearly become an alcoholic and I believe I, there was no debate whether I was alcoholic or not, by the time I was in that position I was alcoholic, I could not drink in a controlled manner and the idea that I could... and it was just classic, I, I did it but I would never give it up completely because it was too important and even when I had it I drank in an alcoholic way because I had it all at once to give me the kick I wanted, I didn't want to dissipate it, I never abandoned the idea of drinking and, um, and it just came back and I drank, , you know, I just drank more and more until I was back and beyond what I was before and I, I believe now that was inevitable." (P6: 159-170)

He was locked into a self-perpetuating cycle. His GP presented him with an ultimatum:

"P6: ... the doctor basically told me my liver was going to fail in 3 months is what he estimated and at that point he, he suggested, that I should, er, I really had to do something about it, I had no choice I either did something about it or that was it." (P6: 122-124)

Joining AA he stopped drinking and surprised himself with the ease by which this happened. Even though he is non-religious, he terms this a "*miracle*" (P6: 195). However, this triggered feelings of guilt:

"P6: ... I have described my particular relationship as an obsession, that's how I characterise my alcoholism as an obsession, a mental obsession and, um, that lifted for me relatively easily and I felt guilty about that, I felt guilty that it had gone so easily because I thought well you should have been able to do this and lapsed back into this way of thinking that it's a matter of willpower, er, and I should have been able to do it before..." (P6: 196-200)

He did not find AA, automatically, conducive: "... *to start with their little sayings irritated the hell out of me..." (P6: 270-271)* and he still maintains ideological differences. He has yet to engage with its 12-Step programme:

"P6: ... the idea that you're going to agree with absolutely everything is, is unrealistic..." (P6: 286-287)

However, in contrast with his family, within AA he is listened to:

"P6: ... I have a very supporting family, but I cannot talk about some of these things to them because they don't understand... you can see them glaze over because they just don't get it at all (laughs) um, and but for one day a week I, the people (in AA) will listen to me..." (P6: 313-316)

Relapse taught him that he was alcoholic but lacked the self-efficacy to control his consumption. By comparing his life experiences with the stories of other AA members, he realised that, despite the unifying nature of AA, there existed differences between its members, primarily surrounding the acceptance of the condition. From his frame-

of-reference, relapse (which is synonymous with alcoholism) was perpetuated by his misguided belief in willpower:

"P6: ... I know that my problem is alcohol and if I don't pick up the first drink I won't get drunk, I know that, but what I began to understand is that it meant more than that and I began to realise that actually, there are many alcoholics who don't understand that, who think that they who think that they will conquer it they still be able to drink and conquer it and there are many professionals as I understand it and as I've experienced, who also think that you should actually learn to manage the drink rather than stop. I think that's a horrendously hard way to control your alcohol." (P6VT: 124-130)

Consequently, he has no specific coping-strategies beyond maintaining a state of vigilance:

"P6: ... there's not a huge amount that I do .... I don't put myself in positions which I don't feel comfortable with, if there's anything I feel uncomfortable with I just don't do it..." (P6: 326-327)

Hearing relapse stories, P6 concluded that it may be perfectly possible to secure a meaningful recovery by means, other than AA. However, because he was alcoholic (identified by the phenomena of his obsession, craving, denial and loss-of-control) alternative routes to sobriety were essentially closed to him:

"P6: ... but the most powerful thing that tells me that I can't have a drink is when people come back in to AA and share about their experiences of having relapsed, no matter how you look at it they are telling you what happened to them and I believe them, or I believe most of them, that they were back in the situation that either they were straight back in the situation, without any delay that they were before they were drinking in the same way they were straight away, or within a matter of weeks they were doing, they were drinking the same way and when they tell me that I believe them ... It is conceivable, and I know this logically that there are people who stop drinking for a long period and then went out and started drinking again and are successfully controlling it, that is logically possible. I haven't met one of those people but I have met the others. It doesn't bother me that it might be possible for some people to do it, because I am convinced I'm not one of them..." (P6: 225-237)

He continues to attend AA once a week as this is where people "*understand*" (P6: 302) alcoholism, so that he develops further insights into his condition:

"P6: ... I think overall you get a growing insight and even even though 3½ years is quite a long time, but there's still plenty of room for your intellect to grow..." (P6: 308-309)

Relapse teaches that alcoholism sets him apart from other people and he accepts the difference that he is unable to drink alcohol:

"P6: ... it's the fact that I'm absolutely clear now and I hold no, I hold no hope that I will ever be able to drink safely again, none." (P6: 353-355)

10.6.1 Summary

As a daily drinker, P6 defines his relapse as the discrete period of time when he tried and failed to control his drinking. He now believes that certain phenomena perpetuated his alcoholism; his mental obsession; craving; denial; and his consummate belief in self-efficacy. He cites no external causes for his relapse. He recognises that he drank not for pleasure, but for an "*effect*" which only alcohol provided. From his frame-of-reference the relationship between any alcoholic and alcohol is founded on the illusory principle of control, a word he uses eleven times within his narrative. By describing himself as a "*functioning alcoholic*" he perpetuated his belief that he could moderate his drinking as and when he chose. This illusion was reinforced by denial. Relapse determined that his recovery is abstinence-based. P6 has yet to engage with AA's 12-Step programme, but sees this as developing a spiritual element to his recovery.

Chapter 11 will discuss these findings in more detail.

11.0 Chapter Eleven: Discussion of Findings

This chapter examines differences/similarities in understanding the interlinked phenomena of alcoholism, being alcoholic and relapse as expressed within the narratives outlined in Chapter 10. It explores a general understanding of relapse; focuses on three areas of significance for ATRF relapse-prevention: i.e. triggers; coping-strategies; and the relevance of abstinence; and offers a description of the personal meaning of relapse for each participant. Finally, it suggests a tentative description of the rôle relapse plays within the stages of the recovery process. I challenge the ATRF's argument that AA recovery-narratives are uniform in nature.

11.1 Introduction

From the findings outlined in Chapter 10, certain inferences could be made which, as AA affiliates, were expressed by the participants as a whole, but which recognises that each experienced particular aspects of relapse (which informed their recovery) in a wholly subjective way. I illustrate these inferences with *in vivo* quotations.

As AA affiliates, a participant's goal of membership was to achieve abstinence-based sobriety by following AA's suggested pathway to recovery:

"Recovery is a journey and you get your sobriety by following the pathway (sic) which AA provides to the best of your ablity (sic). Each member of AA adapts the 12 Steps to their own life; we are all different." (P4: Letter: 29-31)

At the heart of a sustained-recovery lifestyle lies the comparison between what happened at the time of a relapse and how this was, subsequently, interpreted by him/her in relation to the present:

"P5: ... I think I have to have a picture not only of how awful it was in my head, but how good it is now in my head so that I've got those two, er, two things as a as a thing to keep there ... I need to have the the amazing life that I have now ..." (P5: 316-320)

In all six cases, it was the positive meaning with which relapse was, subjectively, invested which supported both their desire to maintain abstinence and adhere to AA's recovery-programme:

"P4: ... The treatment centre got me sober and introduced me to AA...

R: Right.

P4: ... and that's where it ended...

R: Yeah.

P4: ... AA keeps me sober...

R: Yeah.

P4: ... AA, AA has taught me how to live sober..." (P4: 492-498)

As self-labelled alcoholics, they did not describe themselves as being different from (or superior to) other AA members, being subject to the same phenomenon of *alcoholism* (a binary construct of "*addiction or recovery*" P3VT: 142). However, it remained with an individual to determine if and how the label of "alcoholic" applied to him/her and what s/he understood by that term:

"P6: ... I've never in attending AA and I know we're told not to, we're told to look for similarities not differences but I have never, ever thought you're an alcoholic and I'm not. Because once I realised, er, once, once I in the end realised, started to understand that's what I was, the fact that somebody was different in terms of the detail made no difference to me. The way I think of it is that if you were to characterise alcoholism as having 20 symptoms it may have a 1,000 I don't know but if you were to say it had 20, most of us will have 15 some will have 10 some will have 20, but you're still an alcoholic..." (P6: 357-363)

Relapse appeared more than abstinence violation (Marlatt and Gordon, 1985). It shook a participant's belief in his/her self-efficacy, a behavioural construct denoting a person's belief in his/her ability to accomplish tasks or achieve goals (Antony, 2014),

because the outcome returned him/her to the state of active-alcoholism, which was not his/her intention. The option to drink safely and at will was removed:

"P1: ... from an outsider looking in most people think it's a choice and I didn't have the choice, that's how it was for me. I didn't have a choice." (P1: 602-604)

What distinguished them from active-alcoholics was that they had, gradually, secured a process of sustained-recovery which they felt to be an outcome available to all AA affiliates. In short, relapse ceased to be an *active* "learning experience" (Marlatt and Gordon, 1985) i.e. a cyclical process of drinking and relapse attenuation, but a *passive* or one-off "learned-experience" serving as the prelude to their desired goal of developing an abstinence-based recovery:

"P6: ... I learn more about myself and the more I learn about myself the more comfortable I feel about myself and I don't need to change that and I don't want to go back to losing that control. I'll lose me." (P3: 162-164)

What further identified them was their realisation that they could stop drinking:

"P6: ... I think it was easy because I didn't approach it in that direct way of, of, of of confronting it head on and and with the front of my mind consciously sitting there and trying not to drink..." (P6: 201-202)

It was their unique experiencing of relapse which informed their decision to remain sober and served as a daily reminder that: given their personal experiences; the passage of time (*"P3: ... I saw it as learning to drive ... a car..." P3: 180-181)*; and their abstinence-based lifestyle; their lives were immeasurably better without alcohol. How they reached this conclusion was part of their unique journey or process:

"P3: The experiences that I get from other people in AA you take, I take parts of them, the bits that feel like they fit me, the bits that feel comfortable and or more relevant to me, I take them and I use them in my recovery." (P3VT: 390-393)

Implicit in the notion that recovery was a "*gift*" (P1: 675; P2: 514) or the surprise at the ease by which they stopped drinking ("... *I should have been able to do it before..."* P6:

200) caused some participants to infer that serendipity had, potentially, played its part:

"P4: ... I see many, many people relapse over, you know, over time and a lot of them never get back and some, some, some die, some get into dire trouble. I was lucky, I didn't..." (P5: 395-396)

The notion of chance was expressed as being a spiritual dimension to recovery ("*...this is what is described as the miracle in, um, in AA where the obsession lifts*." P6: 195-196).

AA's 12-Step programme fosters reflexivity on how an alcoholic (in recovery) demonstrates his/her moral probity and where the past serves as a moral warning. Significantly, overt statements concerning shame and guilt were noticeably absent from their narratives. P6 mentioned brief feelings of guilt when he had been critical of his family for not fully understanding the principles of his recovery, but this was voiced from the position of his sustained sobriety where, on reflection, during the process of member-checking, he felt such criticism to be uncharitable. P4 referenced his completion of Steps 8-9 which specifically address shame via the reparation for past wrong-doing which had come from his repeated drunken behaviour. However, membership of AA and years of alcohol-free, sustained recovery meant that all participants no longer engaged with shame-inducing acts which could demean them in their eyes and the eyes of others. Instead, their enjoyment of a sober life and pro-social activities meant that they construed recovery positively, concentrating on expressions of gratitude which were reflected in acts of altruism and selflessness. There could be no shame in their efforts to be in recovery.

I now compare the ATRF's theory of recovery/relapse with that derived from the participants' interpretations. This, potentially, contrasts the specificity of ATRF thought regarding the importance it attaches to attenuating relapse by developing a *recovery-lifestyle*, compared with the participants' focus on their need to orientate themselves to understanding what it means, phenomenologically, to be *alcoholic* and their ability to remain in recovery whilst struggling to make sense of the relapse event.

11.2 <u>The ATRF's theory of recovery/relapse</u>

Beyond the prevention (Donovan and Witkiewitz, 2012) and prediction (Cummings et al., 1980) of relapse in alcoholism, much of the ATRF's research focuses on the

methods of developing a recovery-lifestyle, e.g. spirituality (Bowden, 1998); or identity change (Kellogg, 1993; 2003); etc. Where AA affiliation is involved, the ATRF examines its mechanics of change: e.g. longer-term membership of AA (Kelly et al., 2009); regular meeting attendance (Laudet et al., 2002); participation in AA activities (Kaskutas et al., 2002); or completing its 12-Step Programme to sustain recovery (Valverde and White Mair, 1999). AA's sense of fellowship may be an integral therapeutic factor for positive change (Stone et al., 2017).

Rudy (1986) generalises that when AA affiliates describe their transformation from active-alcoholism into recovery, they abandon any personal expressions of their experiences, but mimic the narrative exemplar of Bill Wilson, co-founder of AA, described in *The Big Book* of AA (AA, 1976: 1-17). Wilson's autobiographical account portrays him as an alcoholic reduced to the lowest spoke of fortune's wheel who, subsequently, underwent a spiritual transformation, leading to sustained, abstinence-based recovery. An echo of his narrative is, perhaps, heard in the broadly redemptive accounts within this study, which prize those AA values of personal responsibility which he describes, i.e. the need to develop moral probity and apply this within a recovery-lifestyle (Galanter, 2014).

Rudy (1986) infers, therefore, that there exists an in-built sameness between all AA discourses, as participants seek to affirm their acceptance of AA's philosophy by, correspondingly, playing down their individuality in order to align their narratives with that of Bill Wilson (Thune. 1977). However, having achieved sobriety, Wilson never relapsed and so this particular experience is absent from his narrative account. Hence, relapse narratives are not, I suggest, derived from some AA relapse-template (as none exists) but are, perhaps, the creation of the participants' subjective experiences. Notably, ATRF research is silent on how alcoholics incorporate the phenomenon of relapse within their recovery.

11.3 The participants' general understanding of relapse

Understanding relapse appears to require the creation of a subjective working hypothesis which may not satisfy cogent, empirical study, but justifies their current thought and behaviour. It is based on the fact that they are now living soberly,

allowing them to focus, primarily, on the success of their newly created and developing way-of-being.

In describing relapse, participants borrowed metaphors from AA ("*the four hideous horsemen"* (P1: 2) or created eidetic ones ("*a parasite*" P3: 152); they used medicalised terms "*disease*" (P5: 171) or "*illness*" (P3: 313) but, like AA, not in any medicalised sense; their descriptions were at times haphazard and speculative ("*all could be true and none could be true*" P2: 241-242); or otherwise emphatic ("*in my experience they (relapses) have always, (hits table with hand), always (hits table again) been planned*" P4: 446-447); relapse could be metaphysical ("*some mysterious force*" P3: 26); or rational ("*it was planned*" P5: 26).

Amongst this diversity of expression, five areas of agreement emerged. First, when it happens relapse is negative "*absolute horror*" (P1: 1); "*catastrophic*" (P2: 30); "*incredibly ashamed*" (P5: 11). Secondly, alcoholism (however it was defined) is incurable and that recovery is on-going ("*I'm not cured. Yeah, I'm in remission, um, I'm in recovery*" P4: 392). Thirdly, that AA offers a hopeful means of securing a life of recovery ("*it's a programme for life*" P2: 276). Fourthly, that the relapse stories told in AA are trustworthy and abstinence is necessary:

"P6: ... I am convinced that there are more people like those who come back and tell me it's a disaster to start drinking again and because I am convinced about that I don't pick up a drink." (P6: 239-240)

Finally, although relapse teaches that recovery may be "*fragile*" (P1: "*I think most people's sobriety is fragile*" (P1: 496) it is, nonetheless, achievable:

"P5: ... I... will never ever feel complacent I don't think again about my recovery, I will never think I have it, I've got it, um, I'm happy in my recovery, I'm carefree in my recovery, I love my recovery, why would I want to go back now?" (P5: 313-316)

Whereas alcoholism is a permanent condition, relapse is avoidable given that an individual orientates him/herself towards what it means to be an *alcoholic-in-recovery*. But experiences of relapse were, perhaps, first determined by how the phenomenon

of *being alcoholic* was viewed. For example, if being alcoholic meant an inability to control consumption, then relapse became a matter of loss-of-control:

"P6: ... I only started to get better when I accepted that I had no control over alcohol. The point where I accepted I was alcoholic and the description of alcoholic became comfortable for me ... and the description of alcoholic started to feel something I could start to live with, I could accept I was alcoholic..." (P3VT: 47-55)

If, however, being alcoholic meant having dispositional attributes which sustained alcoholic behaviours, then relapse signalled the need for personality change:

"P4: ... I'm not happy that I relapsed, but, but I think it's probably necessary for me to sit down and have a hard look at myself..." (P4: 393-395)

Relapse was a return to active-alcoholism:

"P2: ... in an instant (pauses), er, my head went that's the only way I can explain it ... I went from being happy, (pauses), er, good with life, (pauses).. thankful,... grateful, (pauses) loving (pauses) to, into the same deep hole just from that one drink that I had been in when I was in active addiction, the same." (P2: 29-38)

Seen in the subjective context of being alcoholic, to be useful relapse needed to serve a purpose, even if it could not be fully explained nor had little relevance for other people:

"P1: ... what I've had to do with my drinking is discover the sense behind it. If there is, but that sense is only for me, I don't believe that's for everybody..." (P1: 257-259)

At the time it occurred, relapse was destructive but, given time, it achieved value as the fulcrum between an alcoholic and a recovery-lifestyle:

"P1: ... I couldn't have thought about it after being sober for 7-8 weeks to think that what I need to do is go and get drunk again. What I had to do is legit... legitimise that in hindsight to think well I suppose if that was my end-game that was the thing that I needed to do to find sobriety today, to find how bad it was or how bad it could be again..." (P1: 227-230)

This meaning could be maintained, provided that an individual remained abstinent:

"P6: ... keeping away from that first drink is my responsibility and it's something that I do consciously all the time..." (P6: 179-180)

In contrast, some viewed relapse as a deliberate, though reckless, test of willpower, (*"I'll think I'll test myself, see if I really am an alkie..." P4: 56-57; "I know I can handle it..." P5: 93*) or a final piece of evidence that confirmed his/her alcoholism:

"P2: ... it could have been to say and this is the last bit of proof that I never will do that never will want to drink again..." (P2: 187-188)

Potentially, being alcoholic does not have to lock a person into a perennial cycle of recovery/relapse. Instead, understanding what it means to be alcoholic carries with it certain responsibilities. These inform how the participants' experiences compared with those key areas which dominate the ATRF's relapse-prevention research; triggers; coping-strategies and the rôle of abstinence. These I now examine.

11.4 Triggers to relapse

The RPM focuses on the antecedents of relapse to determine the taxonomy of potential triggers which precipitate recidivism (Marlatt, 1996). Conversely, although each participant was able to describe specific triggers which, initially, s/he believed occasioned his/her relapse, despite reading AA literature and listening to the stories of other alcoholics, at no time did s/he suggest or consider that there existed a commonality of triggers which affected alcoholics generally.

P1 highlighted an accumulation of anxieties (which he termed "*fear*" P1: 30), caused through: worries relating to work; his relationship with his wife, daughter and family; coupled with his profound sense of guilt that he had failed to meet his own expectations relating to his self-image. Finally, his return-to-work-interview was the straw which "*broke the camel's back*" (P1: 404).

P2 experienced no negative affect ("*I'd enjoyed my sobriety*" P2: 30) but considered that she had become "*complacent*" (P2: 178) in the exercise of her recovery and, not understanding AA's philosophy of recovery, sought to test whether or not she could drink safely ("*Right let's test this happiness!"* P2: 246).

P3 believed that his "*personality*" (P3: 116) was that of "*a drinker*" (P3: 115) and that until he spent two nights in a prison cell, denied access to alcohol, relapse was the "*inevitable*" (P3: 45) outcome of "*wanting to drink again and trying to fight that obsession*" (P3: 16).

P4 believed that the pressures of re-integrating within his family-life rendered him "*ill at ease and out of sorts*" (P4: 46) especially as he was living within his old drinking environment ("*my pub*" P4: 42) and amongst his family which had been psychologically affected by his active-alcoholism.

P5 stated **"***I don't know what caused it*" (P5: 131) as her relapse was not triggered by negative affect ("*it wasn't because I was depressed*" P5: 240) but an intrapersonal feeling of existential longing ("*I wanted to recapture something*" P5: 241) which had been slowly emerging during her two years of sobriety. She also found it difficult to socialise where other people were drinking ("... *not drinking and being with a whole load of people who are drinking is a very difficult place to be..."* (P5: 134-135)

P6 though trying to moderate his consumption (with professional help), found that the epithet of being a "*functioning alcoholic*" (P6: 105) enabled him to continue to drink as he wished. It was only when the physical effects of drinking became life-threatening, that his GP presented him an ultimatum which caused him to embrace abstinence.

Paradoxically, perhaps, what unifies these experiences is that each participant viewed his/her triggers as being idiosyncratic. Subsequently, they all engaged with an attempt to secure sobriety under the auspices of AA and the use of cognitive/behavioural coping-strategies.

11.5 Coping-strategies

In keeping with the psychotherapeutic goal of empowering a person, the ATRF regards coping-strategies as an effective means of increasing a person's self-confidence and self-efficacy (Forcehimes and Tonigan, 2008). Conversely, participants described coping-strategies apposite to particular triggers but based on a self-appraisal of their lack of self-efficacy, which stemmed from their being alcoholic. Strategies were, generally, avoidant, but there were notable differences. For example, when facing any new situation, P5 immediately disclosed that she was alcoholic:

"P5: ... I will come clean straight away and I will say to the person that I am with, I am an alcoholic." (P5: 355)

However, this same technique was only used, by P3, as a last resort:

"P3: ... I have many, many ways of declining that drink, the ultimate one for me is listen I'm a recovering alcoholic, you give me that and you'll kill me and I'd be quite happy to use that if that meant me avoiding relapse...

R: That determined to do it?

P3: ... It's one of the big barriers right at the very end..." (P6: 365-369)

Whereas P2 socialised in close proximity to alcohol and other people drinking, afterwards she would have all alcohol removed from her house. P4 did the same, but also included the removal of drinking paraphernalia ("... *we changed the glasses so all the glasses that I used to use to drink my whisky..."* P4: 355) although believing this to be largely "*cosmetic*" (P4: 150). He was similarly hesitant about going into pubs or social events involving alcohol. P5 found socialising with people who drank "*a very difficult place*" (P5: 134-135) thus engaged in re-affirming self-talk or, wherever possible, physically distancing herself from alcohol:

"P5: ... I have to speak to myself very firmly and sit the far away from the restaurant on the train as possible..." P5: 138).

P6 refrained from entering pubs and would not cook with alcohol, even though cooking was his hobby:

"P6: ... I am more slavishly of the view that I need to avoid alcohol even in cooking and cooking is one of my hobbies..." (P6VT: 252-252)

Otherwise, his primary strategy was to avoid anything which made him feel "*uncomfortable*":

"P6 ... there's not a huge amount that I do, well, um, I live a life where I don't put myself, I do all the things, I, I don't put myself in positions which I don't feel comfortable with, if there's anything I feel uncomfortable with I just don't do it..." (P6: 325-327)

P2 welcomed the fact that her husband monitored her closely, ("... *because he watches, you know*" P2: 465) although P4 regarded such protection from his wife as intrusive, ("... *I'd sort of, sort of cut my wife out of this recovery process ...*" (P4: 215-216).

It was not always the case that each participant believed that s/he had identified relapse-triggers correctly ("*all could be true and none could be true and all could be, all could be tiny contributions..."* (P2: 241-242) so that it was possible to remain sober whilst operating risk-averse strategies, which might not be exactly appropriate, provided that they were predominantly avoidant in nature (e.g. "*stay off the drink one day at a time*" P4: 462-463; "*...not to pick up the first drink*" P6: 252). Similarly, even where self-devised coping-strategies were practised, they might attenuate relapse (for up to two years in the case of P5), but, ultimately, failed. This also applied, in the case of P4, where such strategies had been professionally taught. Strategies, in themselves, were no guarantee of relapse avoidance.

However, identifying relapse-triggers and devising concomitant coping-strategies, which form the mainstay of ATRF relapse-prevention theory, appeared to be only part of their recovery-process. For relapse to be a learning-exercise of lasting value, each participant seemed to imbue his/her relapse with a uniquely personal meaning or *sitz im leben*, which harmonised his/her past alcoholic lifestyle with his/her experience of relapse, viewing both from the vantage of his/her current (abstinent) way-of-living and its affect on his/her immediate environment. It appeared to be more than simply a matter of identity (i.e. "I am an alcoholic") but an awareness of his/her impact on others. For example, when actively drinking P3 could say:

"P3: ... wishes of other people was (sic) that I would stop drinking, that didn't comprehend..." (P3: 55-56)

Whereas, in sustained-recovery P4 could affirm:

"P4: ... I recognise, um, the importance of other people..." (P6: 479)

The secretive, isolationist nature of active-alcoholism had been replaced by an awareness of interpersonal relations, particularly with fellow AA members:

"P6: That's why I think we band together, because we're prepared to to listen to each other." (P6VT: 333)

11.6 The value of abstinence

The RPM argues that the *abstinence violation effect* is an alcoholic's autonomous choice, but may increase feelings of personal shame should relapse occur (Marlatt and Gordon, 1985). The ATRF is divided between the need for abstinence, before recovery-proper can begin (Donovan et al., 2012) and those who argue for developing a quality-of-life which may or may not be contingent upon non-drinking (Tiffany et al., 2012).

Participants, as AA affiliates, had heard stories or witnessed fellow AA members who though, ostensibly, following the same recovery regime, had relapsed and died:

"P4: ... relapse kills, drinking kills..." (P4: 446)

There appeared to be a distinction between becoming sober (i.e. non-drinking) and becoming abstinent (i.e. following a lifestyle which encouraged and made non-drinking personally rewarding). Both P2 and P4 had been sober for 7 and 4 months respectively, but nonetheless felt the need to test whether or not they were alcoholic, even though P2 had previously affirmed that, "*I'd totally accepted I was an alcoholic..."(* P2: 98). P5, who had been sober two years, believed that it was only through her membership of AA that she could acknowledge the need for abstinence:

"P5: ... if I hadn't then gone to AA and gone to meet alcoholics and actually really accepted that I was an alcoholic, I don't think I would have been able to stop ... I couldn't have done it on my own..." (P5: 125-127)

The word "*accept*" pervaded the participants' narratives, but suggested that it involved a process which occurred gradually and that only until they could accept that they were alcoholic (defined in a way which was acceptable to them) could they

acknowledge that abstinence was crucial. This raises the question about what is it that they needed to accept?

This was variously described. For P1 when emotional and psychological difficulties arose alcohol was his "... *default setting … to take away the pain...*" (P1: 404-405). P2 sought emotional stability or a "*warm feeling*" (P2: 27), which alcohol provided, but which she now enjoyed through strong interpersonal relations with her family. P3 only achieved a level of acceptance when he realised that he could not control his drinking:

"P3: ... I only started to get better when I accepted that I had no control over alcohol. The point where I accepted I was alcoholic and the description of alcoholic became comfortable for me..." (P3VT: 47-49)

P4 recognised that he needed to engage, honestly, with AA's abstinence-based programme otherwise he would not "*feel comfortable*" (P4: 301) with his recovery:

"P4: ... I'd been in AA 18 months and and I'd been sober then for 14, what I'm saying was that the, in order to get a true (pause), um, view of why I relapsed, um, it was my journey that I had to, to, to learn the whole programme..." (P4: 280-282)

For P5 it necessitated the realisation of the proximity of relapse, or what she termed "*the bogey man on my shoulder*" (P5: 151) and that the rebellious little girl within her would always seek to "*get away with it*" (P5: 160) if she was complacent:

"P5: ... I need to be aware how easy it is for that to happen and, er, not to push it out of my mind but to actually almost, er, I mean, learn by by the relapses is, is is of course the answer but realise how near I am at any one time in my life, for one reason or another to picking up the bottle which is just at the end of my hand." (P5: 102-105)

P6 moved towards accepting his alcoholism when he abandoned his erroneous belief that he was a "*functioning alcoholic*" (P6: 105) and could admit that:

"P6: ... when I think about a drink I am not thinking about how nice it would be to have a beer, I'm thinking about how nice it would be to have the feeling that beer would give me and how, how to maintain that with the next drink and the next drink, that's what I'm actually thinking about if I'm honest." (P6: 223-236)

The need for abstinence emerged from both their experiences of relapse, but also their experiences of being alcoholic and their subjective relationships with alcohol. It was, perhaps, made more palatable because, first, abstinence was viewed as a choice which could be renewed on a daily basis:

"P3: ... that option to pick up a drink is always there...

R: Yes.

P3: ... I just on a daily basis choose not to take it." (P3VT: 430-43)

But secondly, it was contrasted with the life of active-alcoholism:

"P3: ... because I'm enjoying this journey...

R: Yeah.

P3: ... there is another path, but I choose not to take it...

11.7 <u>The personal meaning of relapse</u>

Participants' attitudes towards triggers, coping-strategies and the need for abstinence combined to determine, in part, their response to their environment which, they perceived, could be threatening, being replete with alcohol and occasions to socialise. Within that response, each participant derived an intrinsically pedagogical meaning from their relapse which motivated his/her cognition and behaviour pursuant to a life of abstinence-based recovery. For example:

P1 believed that he needed to relapse in order to appreciate the "*gift*" (P1: 675) of recovery. He demonstrated his "*gratitude*" (P1VT: 12) for this, by altruistic acts when helping fellow alcoholics. In recovery he found he could be "*good enough*" (P1: 440) without seeking "*perfection*" (P1: 451) in his way-of-living.

P2 argued that her relapse provided the final piece of "*proof*" (P2: 187) she needed to be abstinent; that she had misjudged the principles of AA's 12-Step programme; and that she demonstrated the "*freedom*" (P2: 124) of her recovery by enjoying life, in a social way, without the use of alcohol.

P3 averred that relapse formed part of his "*addictive personality*" (P3VT: 211). To understand relapse could be both counter-productive and dangerous for him, as it could serve as a prelude to further recidivism; "... *thinking that I've totally understood relapse could lead to relapse...*" (P3VT: 238-239). He provided meaning for his relapse by, metaphorically, designating it as a "*parasite*" (P3: 152) over which he exerted control by his current way-of-living.

P4 suggested that relapse caused him to "*take a hard look at myself*" (P5: 394) and review his priorities in life. Consequently, he changed dubious aspects of his personality. Having made reparation to his family, for his past behaviour, he achieved sobriety by practising essential spiritual virtues, principally "*humility*" (P4: 327) and "*honesty*" (P4: 263) with himself and others.

P5 viewed her relapse as "*emotional build-up*" (P5VT: 39) and *"nothing to do with drinking*" (P5VT: 35). As an act of defiance, relapse taught her to forgive her parents for denying her affection and, significantly, she could forgive and release herself from years of pent-up anger directed towards her sister. As a "*non-drinking alcoholic*" (P5VT: 272) her recovery became "*carefree*" (P2: 315).

P6 used his relapse to understand the perversity of his cognition which he termed "*denial*" (P6: 132). Relapse taught him that he thought about alcohol in "*an alcoholic way*" (P6VT: 194) which identified him as being "*different*" (P6VT: 171) from others who drank socially. This awareness "... *makes it difficult to hold and do things which you know are bad and are likely to cause relapse...*" (P6VT: 176-177)

Each participant created a personal explanation for relapse which attempted to: make sense of his/her past; provide a reason for it; and so motivate him/her to pursue his/her own form of recovery:

"P5: ... everyone in AA is so different, we come from different works, um, paths in our lives we're different kind of people, we have our different histories, that have brought us to the stage where we drink and the decision not to drink, again is then again different, the only thing that binds us together, is, is in recovery....

R: Yeah. Okay.

P5: ... and that's different for everybody." (P5VT: 21-26)

However, as AA affiliates, a tentative recovery process can be outlined which was influenced by their membership of AA. I discuss this below.

11.8 Stages of the Recovery Process

The writings of AA (1976), of which all participants were affiliates, explicitly state that its members follow a process of recovery which leads to success:

"*Rarely have we seen a person fail who has thoroughly followed our path.*" (AA, 1976: 58)

That "*path*" incorporates twelve steps of process which are made explicit:

"*Here are the steps we took, which are suggested as a program of recovery*..." (AA, 1976: 59)

The word "*suggested*" implies the efficacy of this programme but not that it is prescriptive. However, in following a published "*programme of recovery*" it may be possible to discern various stages of that process which lead a person towards sobriety and warrants continued AA membership. Relapse is complex and was perceived as a specific moment-in-time (hours or months), which became the pivotal event in their struggle to move from a state where the force of alcohol, perennially exerting its malign influence, was reduced to a state where sustained-recovery was, hopefully, secured. In doing so, they appeared to locate relapse within the broader context of their lifespan as *becoming alcoholic* and, consequently, acknowledging that they had to live with this condition in perpetuity. There is no "*cure*" (P4); there exists the danger of "*complacency*" (P2); and so recovery is viewed as being "*fragile*" (P1).

As Takeda et al., (2013) note, within relapse there are various stages of process (i.e. before, during, ending and following the drinking session). It is possible to detect, within these narratives, general indicators of a temporal process, which do not impinge on the idiosyncrasy of experiencing and can be categorised into three stages. This would be in keeping with the published literature of AA:

"Our stories disclose in a general way, what we used to be like, what happened, and what we are like now." (AA, 1976: 58)

Consequently, participants are, in part, describing and confirming (to themselves) the beneficial effects of AA's implied assurance that relapse-free recovery is possible.

11.8.1 Stage One: losing control (What we used to be like)

This involved the historical acquisition of alcoholism, where the emollient effects of consumption were deemed beneficial. At one point, each participant exerted a degree of self-efficacy over his/her consumption which, while drinking, s/he continued to believe s/he retained. Gradually, their use of alcohol became more frequent and, as its salience increased, they struggled to compensate for the effects of intoxication or manage alcohol's attendant problems. P1 described this when he said:

"P1: ... drinking was fun, and then it was fun with consequences...

R: Yeah.

P1: ... and it just ended up being consequences in the end..." (P1VT: 147-149)

11.8.2 Stage Two: the relapse (What happened)

This comprised the relapse itself. The relapse process could occur after a period of attempting to be sober, but this was not always the case. P6 drank daily, only having an intention of moderating his consumption:

"P6: ... we tried to control my drinking, er, unsuccessfully because, um, although I did cut back I eventually just went straight, went back to where I was before and was drinking at the same levels." (P6: 7-9)

There was no set pattern. Relapse may satisfy a perceived need but, ultimately, what took place was not considered to be beneficial or the outcome did not compliment the intent. For example:

"*P4: ... I did not intend for all that happened in a bad way to happen, that was not part of the intention. I didn't give the outcome much thought at all, I just assumed it would be okay." (P4 Letter 12-14)*

This is often construed by the ATRF as a lack of inhibitory control (Wright, 2011), a view shared by P3 who viewed loss-of-control as the primary definition of what it meant for him to be alcoholic:

"P3: ... there is a stage prior to a relapse for me when (pauses), um, the thoughts of being able to control return or (pauses) or start re-appear and the action of the drinking again to me confirms that there is no control, the control is alcohol controls me I have no control over the alcohol." (P3VT: 42-45)

But P3 had not relapsed since becoming sober, whereas other participants (e.g. P1, P2, P4 and P5) who relapsed after periods of sustained-sobriety, expressed the phenomenon of being unable to stop drinking as, perhaps, attributable to the phenomenon of craving, i.e. that process which P6 described as the tendency or need to drink more, against which self-control proved futile:

"P6: ... I believe, if if I had a drink now, I would, it would trigger the same consequences as it did before and I don't think I'd be able to stop." (P6: 185-187)

A relapse was not the desire to get drunk, but was motivated by the belief that, when problems occurred, life was better with alcohol than without it. In short:

"P3: ... recovery is the fact that they understand that their life is better without alcohol." (P3: 311-312)

For some it was conditioned by a belief that s/he could have one drink, "...*I can just have one drink because I know I'm sober and I know I can handle it..." (P2: 92);* and *"...I bet I could have a drink and never want another one again...." (P2: 191-192).* In such cases, relapse was expressed as the ability to have one drink and stop; or the ability to drink without triggering a need to drink more; or experience adverse consequences. For P4, once drinking commenced, he realised that his need to consume more alcohol grew rapidly and exponentially:

"P4: ... but I'd made my mind up that given another week I'd be back to a bottle and half a day because, you know, it it would it would just progress as quickly as that..." (P4: 74-76)

P1 expressed the unstoppable nature of craving as a lack of "*choice*", doing so by the metaphor of the "*switch*" which seemed to predetermine that cessation for him was impossible:

"P1: I didn't have the choice. No, something had switched on or switched it, or switched off and I didn't have the choice, had to go and do it. (smacks lips) Sssss… it's a difficult one, it's a difficult one to grasp unless you've been there..." (P1: 614-616)

I am not suggesting that participants espoused different taxonomies of relapse, i.e. for those who drank after a period of sobriety, versus those, such as P3, whose relapse formed part of his attempts to become sober. But relapse was perceived and expressed somewhat differently by those who had enjoyed a period of sobriety, where terms of failure, disappointment, confusion and self-recrimination contrasted with the forgiving tone of P3:

"P3: ... recovery has periods of relapse, that's the nature of the illness, but unfortunately, people who even have a strong recovery may relapse. It helps me to see that, because also these people will then get back into recovery and re-evaluate, it doesn't mean they've failed." (P3: 312-315)

11.8.3 Stage Three: acceptance, a new self-construct, strategising and a new journey (What we are like now)

The final stage (or the recovery-process itself) was strengthened and potentially motivated by the relapse experience. This took time and appeared to involve four mutually inclusive stages. (A clinical-model of the recovery process, incorporating relapse, is provided in Chapter 12).

First, acclimatising the self to AA; accepting the label of alcoholic; and determining that AA (and its ideology) could have personal relevance. Secondly, via the new construct of being alcoholic, developing a deeper awareness and honest re-appraisal of the self. Thirdly, creating idiosyncratic and avoidant coping-strategies to reduce all types of risk; and fourthly, by embarking on a spiritual journey of self-actualisation and personal development.

Acceptance involved challenging any doubts that they were not alcoholic and embracing abstinence:

"R: The one thing though that does seem to emerge is that abstinence is imperative.

P3: For me it is yes and the the consensus that I get from from AA is that, you know, the only successful recovery is an abstinence recovery." (P3VT: 34-36)

Relapse enabled these participants to accept the label of "alcoholic". Although AA affiliation appeared beneficial, it did not mean that "*intellectual differences*" (P6: 270) between an individual and its teachings did not arise. AA did not appear to be prescriptive, as each person created his/her own meaning for relapse and determined how this would shape his/her future sobriety. As their self-awareness developed and their past drinking-life was re-evaluated, in the present light of being sober, various coping-strategies were devised which matched specific trigger-points for each individual. It was accepted that what suited one person did not suit another. A striking difference was described (see above) between P3 and P5 as regards the breaking of anonymity where one, openly, declared herself to be alcoholic (P5), whereas the other (P3) would only do so as a last resort.

Relapse did not simply mean ingesting alcohol. It occurred because they were alcoholic and they were incapable of devising any coping-strategy which could alter that fact. This was poignantly expressed when participants acknowledged that the lure of alcohol, despite the damage it had wrought in their lives, remained with them and that no amount of self-efficacy or determination could save them, if they felt that drinking was, once again, a viable option. P1 expressed this idea when he said:

"P1: I realise now as the balance that we've talked about 52 to 48 I was probably running at 52%, er, in, um, relapse and 48% in sobriety...

R: Sobriety, right.

P1: ... and then when it came to a decision should I drink or not drink I would always drink.

R: Always?

P1: Always. Always, if that, even now if I, if I came to a point where I thought, "Should I have a drink?" / "Should I not have a drink?" I would always drink." (P1: 112-118)

In time and in their own fashion their new life of sobriety, incorporating the idea of an addictive-self, *("...I'm an alcoholic who does not drink..." P6: 182*) allowed each person to develop his/her own potentiality. Recovery is a period of *becoming* which stretches long into the future. It is a life characterised by joy, hope and gratitude but above all pride with the self:

"P5: I do believe that I will never be, there is not a cure for alcoholism, so I am very wary I believe it is an illness that will, that it lies dormant and doesn't come out in some people and then develops and and it, I don't know how but I do believe I will always and proudly be an alcoholic." (P5VT: 345-347)

11.9 Summary

There appears to be no collegial definition of relapse beyond it being the ingestion of alcohol. For some relapse came after a period of non-drinking (e.g. P1, P2), for others it formed part of their attempts to become sober (e.g. P6). Relapse is a process and learning to live as a recovering-alcoholic requires time as it "*seeps*" (P6VT: 175) into his/her lifestyle. Yet the lessons learned from relapse appear to be more holistic than the RPM allows.

Relapse, potentially, initiates a process of lasting recovery. First, by consolidating an awareness of a condition which is labelled *alcoholism* and for which participants, subjectively, experience the phenomenon of being *alcoholic*. This helps them, in their own way, to distinguish between the state of active-alcoholism and the desired state of being in recovery or remission. This is their life-goal ("*a way of life that is acceptable to you ... without alcohol*" (P4: 107), without which any meaningful and acceptable quality-of-life is unachievable.

Secondly, by accepting the label of "alcoholic", participants reach an informed decision that abstinence becomes the *conditio sine qua non* of sustained-recovery. Although the prospect of relapse never completely recedes, alcoholism does not have to be a relapsing condition. It is possible to transform a physically, emotionally and

psychologically negative experience, into a seminal, positive life-changing event. This is the most hopeful message of AA and is expressed in the life-narratives of those in recovery. In short, they learn to live with their alcoholism rather than expect a cure. The example of other AA affiliates teaches that alcoholism can be fatal.

Thirdly, the phenomenon of being alcoholic and the need for abstinence requires that they develop idiosyncratic coping-strategies which attenuate emotional mood swings, external triggers and limit cue-reactivity, which otherwise provided the stimulus for recidivism. Additionally, they combat relapse through developing moral qualities and predispositional attitudes (e.g. honesty; humility; altruism; etc) as they embark on a process of becoming recovering-alcoholics. Such strategies are not only directed towards relapse but help form a protective and purposeful process-for-living necessary for any alcoholic obliged to inhabit the world of social-drinking.

Significantly, the participants did not seek to understand a precise construal of alcoholism/relapse holding it to be beyond comprehension. Instead, they imbued relapse with a personal meaning which allowed for abstinence-based recovery or remission to commence and be sustained. It was understood not only as a discrete event in time, but symptomatic of their lifelong relationship with alcohol. How they construed relapse did not have to be empirically sound; it did not even have to make complete sense to themselves or others, but it helped resolve the conflicting, disparate aspects of their growing appreciation of how alcoholism had affected them, day-by-day.

Aided by AA's phenomenological description of alcoholism and listening to the narratives of fellow alcoholics, each life-story (including their own) formed a tiny tessera in the cumulative, expanding descriptive mosaic of the phenomenon of alcoholism/relapse. It is, perhaps, AA's strength that, within its fellowship, all experiences of relapse/alcoholism, however different, are prized and listened to respectfully and non-judgementally. Each experience adds to the totality of a growing but, as yet, incomplete description of the complexity of the phenomenon of alcoholism/relapse, which endlessly baffles those who suffer from it. When P6 says, "...*the people will listen to me and pretend they understand*" (P6: 316-317) he is not suggesting that affiliates are dissembling. Instead, it is an acknowledgement that each

life-story is uniquely personal and is understood, primarily, from a person's own frame-of-reference and in the context of sharing experience.

Relapse represents the inadequacies of their previous drinking lives, but it can only remain so if they remain sober. Though never fully disenthralled from being alcoholic, given time, the personal meaning they attribute to relapse permits them to release their potential as individuals, rendering them acceptable as self-actualising, functioning human beings.

In Chapter 12, I summarise this study and offer a suggested clinical-model which describes the process-of-change, as expressed by the participants, being drawn from and illustrated by *in vivo* quotations taken from their transcripts.

12.0 Chapter Twelve: Towards the construction of a model of recovery suggested by the participants' narratives

This chapter concludes my thesis by offering its findings as a tentative phenomenological model, congruent with and derived from the participants' narratives. This clinical model illustrates the recovery process and the rôle relapse plays in precipitating a person towards active-alcoholism. It suggests that in the life of an AA affiliate, the processes of recovery and relapse are held in tight juxtaposition on a quotidian basis, but that alcoholism does not have to be relapsing.

In this study I have tried to discern the process by which AA affiliates in sustained-recovery (ASR's) perceive the phenomenon of relapse and what sense they might make of it when attempting the gradual transition from active-alcoholism into longer-term recovery. It is a failure to grasp this organisational process which Rosenheck (2001) suggests is, perhaps, the missing link between research and clinical practice. I am not suggesting that the identification of experiential/phenomenological themes (within that process) being derived from participant data is invalid. In fact, I suggest that identifying themes or patterns (by researchers) is a natural corollary of research data analysis. However, I posit that the subsequent *clinical usage* of themes/patterns should be attended by certain caveats.

First, it is highly improbable that any theme (however common or collegial) has been experienced by all the study's participants in precisely the same manner, so that each theme, automatically, carries with it the same meaning for all. The identification of themes runs the risk of downplaying the unique, subjective and intrinsically personal in favour of a common-place and homogenising approach.

Secondly, I question whether a theme, gleaned from the data by researcher reduction can, truly, be said to be reflective of a participant's frame-of-reference or their reflections derived from it, especially if the research methodology is based on the assumption that the researcher (by reason of his/her status *qua* researcher) possesses some inherent expertise otherwise denied to a participant. However well-intentioned, it cannot always be assumed that "Nanny knows best."

Thirdly, any theme is neither static nor can it be treated as a statement of fact on which a generalised hypothesis can be based which could then, confidently, translate into clinical interventions. Research is a *process* not just an *outcome* (Mearns and McLeod, 1984) and given different researchers, participants, methodology, questioning or a different set of circumstances, the findings of research could be radically different. The participants (and researcher) in my study were in a process of what Rogers (1961) terms *becoming*, i.e. an on-going process of personal development so that, if my study was to be conducted now, its findings would probably change.

However, I do not discount the fact that there may emerge an evolving body of core themes or patterns of behaviour/thought (e.g. one's place in the life-course; the fact that the participants were all self-labelled alcoholics; their affiliation with AA; their belief that there was something which could be termed "relapse") which constitute part of a person's lived-experience and which, although subject to continual review, may remain fairly constant. For example, each participant described him/herself as an alcoholic and this view (even though s/he was not drinking) remained and needed to remain, in his/her opinion, immutable. In other words, they chose not to lose sight of their status as alcoholics. The core theme of *being alcoholic* existed, therefore, ("*Once an alcoholic, always an alcoholic*" AA, 1976: 33) which was both in tune with their frames-of-reference and accorded with their phenomenological experiences of alcoholism.

In this concluding chapter I draw together the reflections of the participants, as they emerged during their story-telling and, supported by *in vivo* quotations, illustrate (diagrammatically) a suggested clinical model (or snapshot) of their recovery-process in which they incorporated the phenomenon of relapse. I recognise that this may not be comparable with the recovery-process amongst other AA affiliates and that this model is time-limited to this study. I have chosen to represent my findings in this manner because, in a qualitative study, I believe that visualising a series of incremental images, which complement the participants' narrative-experiences, more readily and less ambiguously communicates the complexity and key features of the recovery/relapse process than mere text alone. In other words:

"… the visual created, based on the researcher's analysis, should show a metalevel of meaning, a meaning that raises above the level of theme." (Scagnoli and Verdinelli, 2017: 1952)

First, I make some general observations which contrast the differences between research-identified themes, serving as explicit research-outcomes of a particular study, with themes of operant process emerging from the experiential storytelling of an AA-affiliated narrative, which form an essential element of the on-going, holistic process of recovery.

12.1 Contrasting themes as research-outcome versus themes reflecting process

Owen-Pugh and Allen (2012: 269) note that, "*alcohol abusers in recovery are a hard-to-reach group – the stigma associated with alcohol abuse can leave many reluctant to revisit their past*". With this I concur (Chapter 8) and it makes intelligible why the bulk of ATRF studies take place within treatment-centres and why, with few exceptions (e.g. Vaillant, 1988, 2003), longer-term studies are regarded as being less practicable and not only for reasons of cost (Gossop, 2008), or participant attrition rates (Barr et al., 1984).

Their article (using grounded theory) focuses on recovery from alcoholism, offering a consensual understanding of the phenomenon of relapse as being "*an inevitable part of recovery*" (Owen-Pugh and Allen, 2012: 271) and, citing Blomqvist (2002), conclude that recovery may, "*best be understood as an identity project*" (Owen-Pugh and Allen, 2012: 267). Through their choice of methodology, they offer certain key themes, all of which make intuitive sense and aim to provide a substantive theory regarding relapse (i.e. that it centres on identity-change) but fail to describe or convey the complexity of idiosyncratic experiencing, as they imply that each participant experiences its various themes in relatively the same way. I am suggesting that if we are to gain a closer understanding of the phenomenon of relapse, there is a greater need to comprehend, if not empathically understand, the experience of relapse as seen through the eyes of the participants themselves.

Etherington (2009) suggests that in the telling of a life-narrative (especially in the case of survivors of personal trauma), the value of story-telling is to help an individual restructure or map his/her own discourse, thereby facilitating connections between aspects of his/her life which were previously disconnected and so fit pieces of the jigsaw in a way which creates a form of "*narrative knowing*" (Bruner, 1987). In other words, the telling of a life-story can create shifts in self-understanding (including identity) which, in person-centred terms, are on-going to the view/development of a self-construct. Research looks at a snap-shot of that understanding which cannot hope to reveal the entire picture in all its complexity.

The fact that the research story/life narrative may, potentially, be published means that the interviewee's discourse and what s/he is trying to say matters. It shows how s/he turns a negative experience into a positive one and which, s/he hopes, may help others (primarily other AA-affiliates) gain some awareness of the phenomenon in question. It also demonstrates the resilience of recovering-alcoholics as, voicing their own experiences, they reach out to help others (who share the same condition) and by doing so help themselves maintain a continuous sense of (on-going) self-transformation. Such acts of altruism in helping to nurture others, *without the expectations of immediate or personal benefits*, serve to build a more rewarding sense of a self-construct (Strahan and Wilson, 2006). In short, I suggest that there is, if not a moral imperative, then at least an ethical respect for their agency which allows the participants, as far as is possible, to speak for themselves without undue interference from the researcher.

Within AA, such story-telling becomes part of a collective narrative of what it means to be alcoholic which overcomes some of the "*isolation and alienation of contemporary life. It provides a sociological community, the linking of separate individuals into a shared consciousness*" (Etherington, 2009:231). Even though the research participants may not meet each other, as members of AA, they form part of a worldwide organisation which they will never know in its entirety; nevertheless, they can feel included in a shared community. AA provides them with a sense of hope and an alternative way-of-living which they believe works and in which they can trust, as well as a feeling of being part of something greater than an individual.

Each story, so far reviewed, whilst it may be made with reference to the teachings of AA and its published and widely disseminated understanding of the phenomenon of alcoholism, is primarily related to the personal, internal and experiential state of each participant and his/her view of the phenomenon of relapse as it was shaped within certain contexts, relationships, feelings and events which relate to each as an individual. Another important aspect of each life-discourse is that each describes an active process of restructuring or sense-making of their experiences (as they understand them) from the vantage point of their current recovery status. As such, their stories are a retrospective recounting of past events through the lens of a current and evolving awareness of what it means to be an alcoholic-in-recovery. In this study the participants believed that this could not be realistically attempted if they were still consuming alcohol.

Each participant had moved through a state of active-alcoholism/relapse and emerged, via a process of recovery, underpinned by AA, into the sunlit uplands of on-going recovery (Stone et al, 2017). This was their story of their journey. As AA affiliates it may be that such stories (or journeys) bore marked similarities to AA's collective discourse of what it means to be alcoholic and they were happy for such inferences to be made. Indeed, at times, some willingly sought to align their narratives and understanding to this collective description, for example, through the use of metaphors drawn from AA:

"P1: ... there is this camaraderie which is suggested in the Big Book that, er, we are like the, er, people in the ship wreck who find the lifeboat and from the captain to stowage we are all the same, we've all been through that experience and we've survived..." (P1: 639-642)

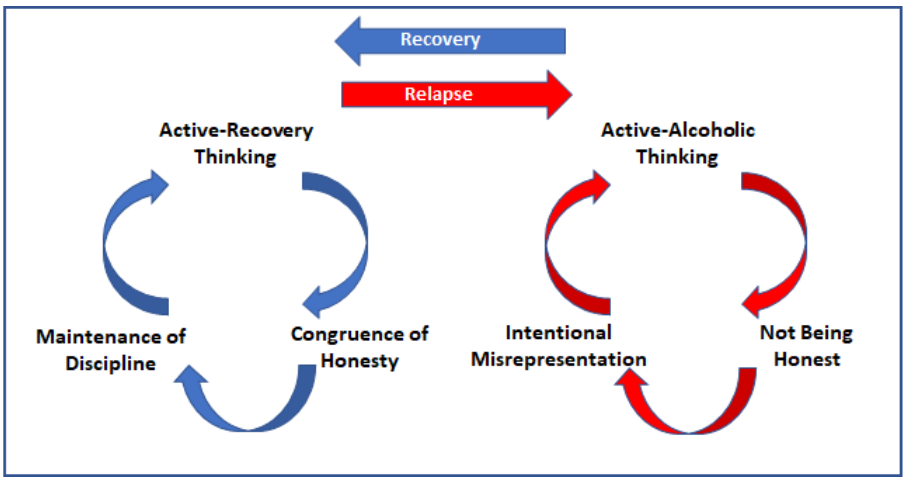
But what they were describing, through these stories, was their forward trajectory of life, so that it is their *process*, rather than an endpoint of having constructed a life story *per se*, that held the greatest benefit to them. As P4 stated, "*Recovery is a journey not a destination*" (P4: 511-512).

Story-telling was being done with the benefit of hindsight and with all the restrictions of historical self-reports (e.g. forgetfulness). However, there was a cathartic benefit (for example P1) derived from recalling the experience of his relapse and holding that

remembrance in tandem with his current, vibrant way-of-living. The one served as a salutary lesson from the past as to what might happen if he did not sustain the process of change and so the fear of relapsing was maintained; the other re-affirmed the gratitude he felt from having escaped, quite literally, from the jaws of death, for the gains he had made, the life he now lead and his aspirations for the future. In some cases (e.g. P1, P2), the somatic-memory (an implicitly bodily felt-sense) remained, even if some of the cognitive-memory did not (Levine, 1997; Rothschild, 2000). But the life of alcoholics-in-sustained-recovery (ASR's), who have experienced relapse, is constantly unfurling and moving forwards in ways that contextualises their recovery in the moment ("*one-day-at-a-time*" P4: 163) and within the cultural milieu of their daily life and membership of AA. This was their process of *becoming* (Rogers, 1961).

An argument, posited by the ATRF, for the need for researcher expertise is the ambivalence with which self-report is, sometimes, held (Sharpe, 2001). However, the narratives within this study suggested that each participant was engaged in a process of trying to be honest, primarily with him/herself. They needed to symbolise, accurately, the effects they had experienced of both alcoholism and recovery and this research-process tended to help them. This had a cyclical aspect. In other words, if they had engaged, with deliberate intent, in misrepresenting their life-stories, then they were not being, or attempting to be, honest. If they were not honest, then they were not thinking as if they were alcoholics-in-recovery, which demanded rigorous self-honesty. If they were not thinking like alcoholics-in-recovery then the likelihood was that they were in danger of reverting back to thinking like alcoholics-in-active-alcoholism, one of the characteristics of which was to practise dishonesty. If they were thinking like alcoholics-in-active-alcoholism then active-drinking (relapse) would not be far behind. Diagrammatically, this can be illustrated as follows:

Figure 1:



I believe that in understanding the phenomenon of relapse (in the context of alcoholism) an account needs to be made of the process of that understanding. In other words, how they reached that (historical) point where drinking became imperative, versus the formation of their current attitudes, thoughts and behaviours where no matter how salient consumption appeared, they chose to remain sober. Recognising the essential difference between these two points of *process* is that which the participants labelled *recovery*.

It could be argued that *process-of-recovery* is a master theme in itself, but process is an action (perhaps) which exists within a temporal context. Two master themes, within this study, are *active-alcoholism* and *active-recovery* where relapse mediates between the two; the one where it is embraced, the other where it is avoided. *Time* is not a discrete theme, but contextualises these two master themes within a temporal framework which reflects not only the movement from one state to another (alcoholism-to-recovery/recovery-to-alcoholism), but also the particular development of an individual. But each master theme is described, by participants, as being experienced very differently.

A second point, which I sensed emerging from these transcripts, was that the narratives and the overall discourse of AA, was strikingly thematic in itself without needing, necessarily, any further overlay of a researcher's interpretation or the creation of new descriptive titles. For example, the state of active-alcoholism which, because the participants chose to label themselves as being permanently alcoholic

may, in this instance, require the parenthetical "active" to distinguish it from its "remissive" state. Active-alcoholism was described as *"serious drinking*" (P5: 43); "*my drinking*" (P2: 143); "*alcoholic fashion*" (P1: 39-40); "*alcoholic drinking*" (P3: 8); "*drink like I used to*" (P4: 102) and, consequently, formed a master theme of its own, but derived its compound meaning from the personal frame-of-reference of each participant. In all cases these themes were experienced in an intrinsically subjective way.

Each knew what it meant for him/her to be alcoholic, but this did not equate to each holding the same understanding of the phenomenon. For example, P6 used the phrase "*functioning alcoholic*" (P6: 106) to describe his active-alcoholism in a precise and idiosyncratic way. The idea of *functioning* was also mentioned by P1 (312ff) in order to describe his drinking as a method of overcoming a daily state of tonic fear, whereas P3 (50ff) referred to *functioning* as the means by which he consumed alcohol but without, he believed, anyone suspecting that he had been drinking, so as to avoid negative consequences.

P6 was quite open about his drinking and did not, necessarily, seek to hide it. For him, *functioning* meant that he used alcohol not only as a stress-releasing agent at the end of the day, "*to mark the passage from work to when I stopped and I would stop, I would stop working and I would then be relaxing and drinking, and the two things were the same...*" (P6: 31-32), but also to demonstrate to himself that he was in control of his drinking, the proof of which was evidenced by the fact that he steadfastly refused to drink before a given time:

"P6: ... but I considered myself to be particularly functioning, I thin.., I, I, was under the illusion that I that I controlled my drinking (laughs). It seems farcical in, in retrospect, but I had a clear idea that I controlled it because I didn't have a drink until 5 o'clock or half past four or whatever it was in the day (laughs) because I controlled that I thought that I was just using it as a release at the end of the day, but in retrospect I wasn't." (P6: 105-110)

Functioning may mean, for some, either: the temporal control of consumption to indicate that there were no serious problems being experienced; or the ability to drink alcohol without detection; or as a means of reducing tonic anxiety. Neither female participant used the word.

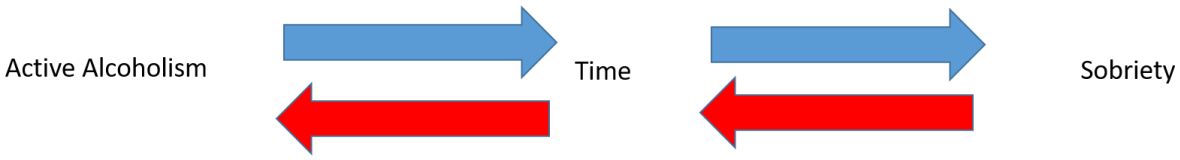
Active-alcoholism was counterbalanced with the positive master theme of *sobriety*, which described the subjective quality-of-life that was achieved by not drinking and attending AA; sobriety is, in this sense, *active-recovery*. Sobriety is also a quality-of-life and does not only mean the external trappings of daily living (e.g. employment, family, friends, financial security, etc.) but includes internal qualities (e.g. self-esteem, self-worth, absence of obsessional thoughts, etc.) and dispositional characteristics (e.g. morality, virtues, commitment, consistency, etc.) which a recovering-alcoholic now values.

Being *in active-recovery* (though the words *recovery* and *sobriety* were often used interchangeably) appears to refer, more accurately, to the way-of-being or processes/method(s) which an ASR employs to gain his or her *sobriety*. Both *recovery* and *sobriety* are determined by the fact that s/he is at all times sober. *Sober* (or total *abstinence*) is, ubiquitously, understood to mean the non-consumption of even a single alcoholic beverage and *relapse* meant the consumption of a single drink or even, in the case of P2, a mouthful of alcohol. In identifying the master and subordinate themes *of process* emerging from this study, I felt it to be more appropriate, wherever possible, to employ those words used by the participants themselves. In representing their words, intentions and feelings I simplified some of their phraseology but I have done this sparingly and only after it had been validated by the participants. Words such as alcoholism; relapse; recovery, sober, sobriety and abstinence remain.

12.2 **A tentative model of process as it emerged within this study**

I now outline a tentative clinical-model which, I propose, represents this movement from one theme (the state of *active-alcoholism)* to another (*sobriety, a quality-of-life gained in active-recovery*) in a cruciform fashion, as being reflective of a recovery-process. This is derived from the phenomenological experiences narrated by the participants. The horizontal line of the cross can be shown as follows (the relevance of the arrows is explained below):

Figure 2:



Within the life of *active-alcoholism* the state of *sobriety* is not reached until such time as an event (or change of heart) occurs which allows an individual to begin to move into a lifestyle of *recovery* typified as non-drinking (*sobriety*). Whilst, for some (e.g. P3) it is possible to indicate a single event which triggers this move towards a need to be sober, for others the process of change appeared, more generally, to be occasioned by a penumbra or aggregation of many single events which was more complex and may even be unknowable in their entirety:

"R: For you, it it the moment that you began to accept "I have a problem" was when you woke up in a police cell...?

P3: Exactly.

R: ... and at that point...?

P3: I made the connection, at at at that point in that police cell I'd made the the connection that the problems were being caused by al... alcohol. I hadn't quite made that next step, therefore, that makes me an alcoholic. It took a short while to realise to take that next step to think, anyone that has a problem with alcohol may be alcoholic and it's it's that, and it and it seems so obvious but that's the befuddled person I was...

R: Yes.

P3: ... at that point. I knew at that point the problem was alcohol, (pauses) to describe myself as alcoholic took, took me to be around other alcoholics and to say, I, I fit in here." (P3VT: 97-108)

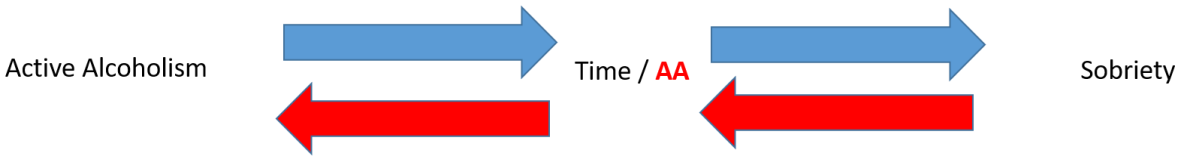
Recovery is the means (thoughts, behaviours, coping-strategies, affiliation with AA, self-awareness, commitment etc.,) by which the state of *sobriety* is achieved and maintained. The prerequisite of *sobriety* is to be *sober*, i.e. recovery is, first and foremost, about living a life which is abstinence-based. *Sobriety* is precarious; the

temptations and urges to drink which surround an alcoholic are multifarious. Consequently, recovery has to be learned, practised, nurtured and only becomes lasting when a participant begins, even minimally, to connect with AA and its operant processes (Greenfield and Tonigan, 2013). Above all, *recovery* has to be personalised to the needs and circumstances of an individual and is secured by habituation.

Effectively the process of *recovery* begins with the influence of AA for three specific reasons. First, AA offers a potentially plausible explanation for, or way of understanding what, has been going wrong in their lives or at least provides an acceptable definition of the condition (e.g. illness) from which an individual begins to make sense of his/her past experiencing of obsessive/compulsive drinking. Secondly, it offers a means by which s/he can remain sober (affiliation with its members) and learn an alternative way-of-being (the 12-Steps) which does not require the use of alcohol. Thirdly, it offers a forum (the group-meeting) in which an individual can share his/her experiencing, gain understanding and feel understood or listened to and enjoy a sense of belonging.

In the lives of these participants, AA became part of the *process* of recovery or the moving from a state of *active-alcoholism* into a state of *sobriety*. It provided the gateway through which *sobriety* was approached. AA may be a master theme, but it is also an operant process (i.e. getting well via the 12-Steps) which means following a sequential procedure of developing self-awareness, personality change and spiritual improvement which was experienced differently by each participant. I would, therefore, now add AA to the horizontal plane as follows:

Figure 3:



This diagram currently reflects the fact that an individual moves (hopefully) from *active-alcoholism*, through time and their use of AA, into an on-going process of sustainable *sobriety*. The key here is to recognise that the goal of each participant,

having become *sober*, is to stay that way; relapse disrupts this process. AA may provide suggestions as to how this is achieved but, ultimately, each person has to find his or her way through the maze of daily-living and to do so in a sober fashion. The horizontal plane of this cruciform model is true to a participant's narratives because the process (recovery) of moving from State A (*active-alcoholism*) to State B (*sobriety*), may, ideally, occur in a decisive, linear movement but, as was reported by them, was more likely to be found as a process of *oscillation*.

In any one day an alcoholic (even if an ASR) moves, as his/her mood fluctuates or when facing phasic, contextual stressors, between the states of relapse and sobriety, but s/he is able to remain sober by maintaining his/her recovery (way-of-being) moment-by-moment and in reference, *inter alia*, to what s/he has learned in AA. P3 provided an example of this. On the one hand, he had maintained a static, core belief (*"I am alcoholic*") on the other, he built certain key parameters of thought and behaviour (i.e. coping-strategies which he labelled "*barriers*" (P3: 247) around this central core but which changed in harmony with his current appraisal of any given situation in which he found himself:

"P3: …What I can do is if someone in AA (pauses) relapses or is around somebody else who relapses I can learn from it, it helps me to build the barriers, it, I, but (pauses) I can't say that if I hear someone, (pauses) if I hear someone in AA that's relapsed I don't think oh well I best redouble my efforts because if I think I need to redouble my efforts I'm not doing it right." (P3: 326-330)

The blue arrow represents a positive move in the direction of sobriety and the red, a retrograde movement back towards the potential to a return to active-alcoholism:

"P1: ... I do use the analogy of that, um, I'm 52% sober and 48%, um, in relapse and as long as those two don't come together I'm OK and I'm fine and I can keep my sobriety....

R: So you're both, you're both in relapse and in recovery....?

P1: Yeah.

R: ... at the same time?

P1: At the same time, yeah.

R: So it's not an either or....?

P1: No.

R: it's both...?

P1: ...it's both, together...

R: and that 52 and 48% is the...?

P1: ... is, is good, is a good place for me to be, 'cause the 48% I know where than can be and the 52%, I know how good that is. And that sometimes I can be 99% sober and 1% in relapse and that, those those are fantastic days, but even at 52/48 there, it's still an incredible day from where I've been." (P1: 76-91)

It is this process of *oscillation* (their reaction in-the-moment to what life places before them) which the participants, consequently, believe renders recovery fragile and requiring constant vigilance. Fragility, in this context, may mean either a challenge (or fragmentation) to their core belief of being an alcoholic and/or an increasing (or developing rigidity) which equally helps distort their self-concept, i.e. their belief of personal self-efficacy ("*I never will go back, I bet I could have a drink and never want another one again...*" P2: 191-192), or both. This is because the weft and weave of life continues to serve up the same stressors and problems in active-alcoholism as well as in recovery, which have to be faced and dealt with:

"P1: ... I think most people's sobriety is fragile, er, even though they may be 30, 40, 50 years into it, there is a fragility about the sobriety because what took us to that point in the clamours of life is exactly the same as it was then as it is now. It's just that we're better equipped to deal with it and we know the consequences of where it will take us or where it had taken us, had taken us." (P1: 496-500)

The representing of this aspect of alcoholism as a process of *oscillation* was endorsed by P3:

*"**R: ... you're moving towards relapse. If you're if you're tired and frustrated or whatever again the barriers are falling, you're moving towards relapse...***

P3: Uh, hm.

R: ...so it's not a, it's not an either or in a sense, it's you're oscillating all the time during the day...

P3: Yes.

R: ... but at the end of the day, if you've veered more towards recovery than relapse and your head's sober when it hits the pillow...

P3: That's been a successful day.

R: ... that's been a successful day.

P3: That's been a successful day and, and during that day when there are events that push me and the barriers are coming down what I attempt to do is have moments of reflection…

R: Yes.

P3: ... in the day, where I can just assess how I feel, where am I, just give myself that moment of to look at where I feel I am in the day and it gives me the chance maybe to take that step back." (P3VT: 160-173)

Recovery is the process by which an ASR seeks to reduce the *oscillation*. This (thematic) process may be given a descriptive title which is *personalising*. *Personalising* is an individual's own application, understanding and adaptation of what it means to be an ASR both through his/her own experiences and listening to those of other alcoholics. They can also compare their experiences with AA's (AA, 1976) substantive phenomenological description of *alcoholism*. It is the process by which an individual develops an ownership or *acceptance* of what it means for him/her to be *alcoholic*; the means by which s/he will generate a recovery-orientated lifestyle; and create harmony between the totality of all experiences in such a fashion as to make the label of *alcoholic* acceptable to him/herself. This process is on-going and is summarised by P3 when he says:

"P3VT: The experiences that I get from other people in AA you take, I take parts of them, the bits that feel like they fit me, the bits that feel comfortable and or more relevant to me, I take them and I use them in my recovery. I don't, sometimes people can use AA more verbatim and they'll take the terms and use them exactly and in a way maybe why I haven't used some of the, the words like gratitude and humility (pauses) in when we spoke last time because hopefully in a way, I've, I've, I've, I've learned what they mean to me and made them more my own.

R: Yes.

P3: So the word is relevant but but the feeling is more personal. So it's kind of like feeling a..., feeling a word, instead of expressing a word...

R: Right.

P3: ... if that makes sense..." (P3VT: 390-400)

Personalising represents the ideas of "*feeling a word*" and "*made them more my own*".

The ebb and flow between active-alcoholism and sustained-recovery is perceived to be the natural, daily state of what it means to be *alcoholic*. As the ASR makes his or her recovery more personal, so his or her acceptance of his/her condition deepens, indicating a fuller appreciation of his/her understanding of Step 1:

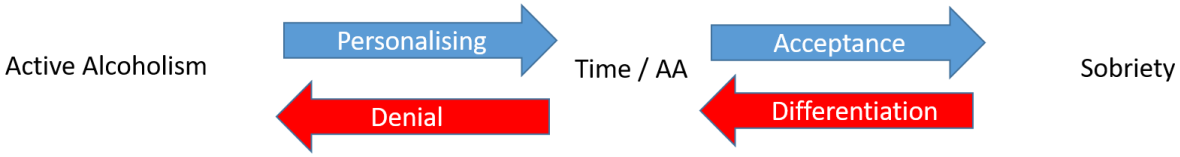
"We admitted that we were powerless over alcohol – that our lives had become unmanageable." (Step 1, AA, 1976: 59)

Recovery (i.e. the means by which a state of sobriety is achieved and maintained) is a highly individual construct which is forged on the anvil of experience. Sobriety here means a personally defined *quality-of-life*, lived without alcohol and based on the tenets of AA's philosophy. It is a complex admixture of whatever outcome (or life-quality) an alcoholic hopes to achieve for him/herself; the code of morality, or qualities of personality, by which s/he now leads his/her life; the depth and seriousness by which s/he affiliates and engages with AA and its precepts; the levels of support and assistance s/he believes s/he requires to help him/her; the nature and extent of the coping-strategies s/he requires to ensure a feeling of safety. It is a style-of-living, a set of principles, beliefs and behaviours and their total way-of-being, which is dynamic and

evolving, but is not conditioned by the length of sobriety ("*recovery isn't the fact that they have been sober for year after year after year, recovery is the fact that they understand that their life is better without alcohol" P3: 310-312*).

In other words, whilst the threat of relapse remains for any alcoholic, thoughts of drinking can be contained because the life-enriching gifts of recovery, which are about to be thrown away at the critical moment of choice, reduce any need or attractiveness of alcohol. Consequently, the model can be refined by adding the words personalising/acceptance to the blue (positive) arrows to indicate the process of developing sobriety and the words "*denial*" (P6: 132) and differentiation to the red (negative) arrows to indicate the opposing process:

Figure 4:



Personalising/acceptance reflects AA's mantra to which P6 refers when he says that alcoholics are encouraged to look for the similarities, not the differences between experience:

"P6: ... we're told to look for similarities not differences but I have never, ever thought you're an alcoholic and I'm not..." (P6: 357-358)

Acceptance is a higher form of identification (Sachs, 2006) and is not merely an intellectual exercise, but a visceral, emotional and psychological acknowledgment and alignment of the self-construct to the identity of being *alcoholic*. Conversely, the red arrows (denial/differentiation) indicate how an alcoholic appears to move away from the label of alcoholic, by denying personal experiences and effectively looking for the differences (between experiencing) which reinforce the belief that alcohol is not a problem. An example of this oscillation process is provided by P2 when she affirms

that, "*I'd totally accepted that I was an alcoholic...*" (P2: 98) (personalising and acceptance) and yet, in virtually the same breath, opines, "…*I bet I could have a drink and never want another one again....*" (P2: 191-192) (i.e. denial and differentiation).

It is this thought process which, if left unchecked, will lead to the consumption of alcohol. Relapse is a process which begins with a thought which, in turn, becomes dominant (or obsessive) in the mind of these alcoholics which, ultimately, leads to the compulsion to ingest alcohol. This process is described by P4 as an act of volitional "planning":

"P4: ... relapse, slip, call it what you will, it's and in my experience they have always,(hits table with hand), always (hits table again) been planned ... I think there's always been a, um, a thought process that that made them amenable ... to to doing that..." (P4: 446-454)

Within this developing model comes a vertical line which delineates *relapse*. If an alcoholic continuously moves (*oscillates*) between the states of active-alcoholism and sobriety, then *relapse* fractures that movement by pushing the pendulum of *recovery* squarely towards the state of *active-alcoholism* and away from *sobriety*. *Relapse* may not only prevent an alcoholic from securing any lasting *sobriety* but, equally, will undo those initial gains made in an attempt to stay *sober* over a period of time, thereby causing additional distress or incongruence:

"P2: ... if I could have vomited that drink up in that next second I would have done, um, because in an instant (pauses), er, my head went that's the only way I can explain it. It was like something catastrophic had happened to me, er, because I'd I'd enjoyed my sobriety and never intended to break it, (now becomes emotional) and the family was happy I was happy and it was catastrophic, it was one drink..." (P2: 28-32)

A common theme of this process, within the transcripts, was that the relapse returned a person, immediately, to the state of active-drinking. P1 expresses a fairly typical example of this recrudescence:

"R: ... The most important lesson would you say that you, you learned from the experience of a relapse, what do you think that would be?

P1: (Pauses). Experience? (pauses) .... How quickly you go back to exactly where you were. The period of time is probably milliseconds from taking that first drink, all the all the old symptoms fears, er, (pauses)...purposes, all the old rules of how you live your life comes straight back (snaps fingers) and how your perception of how things are which have no reality, a lot, lot of it, all the stuff that I had in my head was made up in my head, er, and it goes straight back to there in (snaps fingers) just like that, where you've had, had, you've been having good thoughts and straight lines, um, end and start points, it all of a sudden, "choo!" (snaps fingers) within milliseconds and it's how quickly you go back to an arsehole in the blink of an eye." (P1: 543-553)

Even P2, who consumed a single mouthful of alcohol, reported the immediacy of a negative change within her:

"P2: ... because in an instant (pauses), er, my head went that's the only way I can explain it." (P2: 29)

P6 notes that this is also a common theme within tales of relapse heard within AA meetings, so that it can be said to have a general currency within AA:

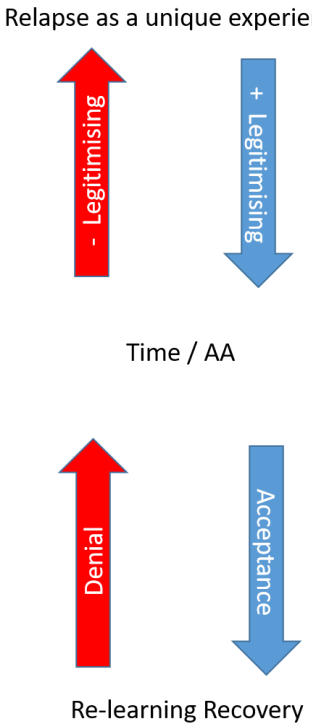
"P6: ... when people come back in to AA and share about their experiences of having relapsed, no matter how you look at it they are telling you what happened to them and I believe them, or I believe most of them, that they were back in the situation that either they were straight back in the situation, without any delay that they were before they were drinking in the same way they were straight away, or within a matter of weeks they were doing, they were drinking the same way and when they tell me that I believe them, I look at them and I make up my mind whether or not I believe them and I do believe them..." (P6: 227-233)

Relapse removes the lynch-pin of *recovery* as an alcoholic is now drinking and, therefore, is no longer physically *sober* or being outside recovery is, psychologically, in a dangerous place. It is something more than returning to square one, as it is accompanied by "*remorse, horror and hopelessness*" (AA, 1976: 6) in acknowledging that they have, knowingly, denied to their experience a critical component of what it means, phenomenologically, to be alcoholic; alcohol means suffering (AA, 1976).

Furthermore, it reintroduces the cognitive, behavioural and sometimes physiological aspects of *active-alcoholism*.

The vertical directional line of the cruciform model, therefore, reads:

Figure 5:



The presence of *Time* and *AA* at the centre of the cross still applies because, first the temporal context of recovery/relapse is within the continuum of an individual's lifespan and so is a constant (which ASR's measure as one-day-at-a-time); and, secondly, because ASR's, in the course of their recovery, contextualise their alcoholism within AA's phenomenological understanding of what it means to be *alcoholic*. For those who attempt a life of *sobriety* through AA, it becomes the lens through which recovery/relapse is viewed. This is more than an *abstinence violation effect* (Marlatt and Gordon, 1985) or some unfortunate or regrettable correlate of choosing to drink. For an ASR who is affiliated with AA, it means the planned and conscious decision to refute the self-construct of what it means to be alcoholic, which s/he has previously affirmed, especially in terms of self-efficacy or self-agency. This decision may not be immediately realised and becomes the subject of a secondary process which may be termed *legitimising*.

Legitimising is a sense-making process which is granted through hindsight and sober reflexivity (and so can only be effected through sustained *abstinence*) but, ultimately, does not, necessarily, seek to explain causality. It can be both positive and negative, in

which case the latter may be termed a form of *denial*. Positively, it rationalises the act of *relapse* as, in some cases, being a necessary part of gaining an understanding of the phenomenon of alcoholism, so that an ASR comes to believe or justifies the *relapse* to him or herself as being a necessary learning-process:

"P4: ... in some ways I'm happy that I relapsed in the fashion that I did, I mean, I'm not happy that I relapsed, but, but I think it's probably necessary for me to sit down and have a hard look at myself..." (P4: 393-395)

Legitimising (as a phenomenological theme) originally derives from the transcript of P1, when describing his relapse (*"the only way I could legitimise it in my own thinking was it was something that I had to do*" P1: 222-223). It, mercurially, refers to a process whereby even a negative act like *relapse* is turned to advantage by an ASR into becoming a positive learning-experience, as it leads to the benison of sustained *sobriety*. This, therefore, can be represented as *positive legitimising*, which in time leads to a state of *acceptance*.

The obverse or antithetical *negative legitimising* is where an alcoholic (when in active-alcoholism) refuses to draw any conclusions, which could materially cause him or her to engage with a process of change, which would inevitably include the need to be *sober*. (It may be true to say that the fact that s/he would now be intoxicated means that s/he is cognitively incapable of making such a rational distinction). Such negative legitimising will, again, be termed *denial* and is a word drawn from the narrative of P6 in describing his refusal to accept that he was alcoholic (*"I was in denial, partly thinking that I was being very honest about it and understanding it but partly I could see in retrospect I didn't understand it at all..."* P6: 132-133); the word is also supported by AA (1976).

Positive legitimising, therefore, may not make rational sense nor does it have to be a water-tight explanation for what has happened. But it is an individual's own means whereby s/he first: recognises the dangers of alcohol consumption and any belief in his/her own self-agency; and, subsequently, precipitates the need for change and justifies his/her adoption of an abstinence-based lifestyle. This significantly increases and validates the choice of AA membership and acceptance of its precepts, foremost

of which is an in-depth analysis of self (i.e. Steps 4-9). Ironically, for an ASR, *positive legitimising* may result in a negative or non-existent rationalisation as to why relapse happened in the first place. On the one hand, it may offer a smorgasbord of reasoning which is effectively indecipherable:

"P2: ... do you know what I mean I'd thought of lots of different things and all could be true and none could be true and all could be all could be tiny contributions." (P2: 241-242)

On the other hand, the desire to understand the causality of relapse or why an individual became alcoholic in the first place, may even be counterproductive:

"P3VT: And I think it always will be a mystery (pauses). I, if I ever thought I knew what it was or I'd cracked it, I'd be worried because that would be a step towards thinking I was cured...

R: Yes.

P3: ... and if I, if I knew everything about it and I'm cured, the illness would twist that against me and I could start thinking well if I'm if I'm cured I have the chance of a drink again.

R: Yeah.

P3: So, thinking that I've, thinking perversely, thinking that I've totally understood relapse could lead to relapse.

R: Yeah. Yeah.

P3: That just shows how much I don't understand about it (laughs)." (P3VT: 232-241)

The difference between *positive* and *negative legitimising* (or *acceptance* and *denial*) is perhaps best expressed whereby an individual has chosen to believe and trust in his/her own self-agency and efficacy, in being able to handle alcohol consumption once again; i.e. the notion of *control*. In which case, s/he believes s/he is exhibiting negative and relapse-orientated dispositional qualities (e.g. belligerent denial,

arrogance, or complacency) versus the practise of *autonomy* which means that an alcoholic chooses to accept that s/he is alcoholic and that the acceptance of this identity means that s/he can never drink again (even if acknowledging that, occasionally, s/he may wish to).

An exemplar of this form of *negative legitimising* or *denial*, which exhibits the hallmarks of such relapse-oriented dispositional qualities, is given by P4 where he undermines his own acceptance of Step 1 (his admission of powerlessness and unmanageability), by legitimising that he is safe to drink again, despite the problems it has already caused him and his family:

"P4: Um. At that point I didn't understand why, I think it was it was a matter of, I think I'll test myself, see if a really am an alky, um, and I started thinking about the unmanageability of my life and I thought well it can't have been that unmanageable? You know, I've been running a successful business, I'd never been to prison, I'd never been arrested, my wife left me but she came back very quickly, the kids were again talking to me, um, I wasn't in financial trouble so all these things were sort of sitting in the back of my mind but I I I didn't tell anybody what I was thinking..." (P4: 56-61)

AA is not prescriptive or dictatorial. The choice to label oneself as being alcoholic (primarily recognising the limitation of one's own powerlessness and unmanageability around alcohol) is made volitionally and is based upon an honest appraisal of the sum of past experiences with alcohol. Critical to the process of *positive legitimising* is the rôle of personal development (including self-awareness and reflexivity) enhanced by a following of the 12-Step programme. An individual may relapse if s/he believes *in any way* that s/he can drink without there being any negative consequences or that s/he can control the outcome. However, minimal this thought might be, in time it may grow to the extent that s/he may seek evidentiary proof of this fact. *Negative legitimising* operates prior to the relapse, when s/he is ambivalent about his/her self-agency over alcohol:

"P2: ... I bet I could have a drink and never want another one again...." (P2: 191-192)

but positive legitimising works, with hindsight, when s/he is trying to make sense of a relapse:

"R: ... How did you make sense of that relapse in order to be able to stop?

P1: To come fr.. and walk away from that I had to accept whether this is right or whether this is wrong, but the only way I could legitimise it in my own thinking was it was something that I had to do.

R: You had to relapse?

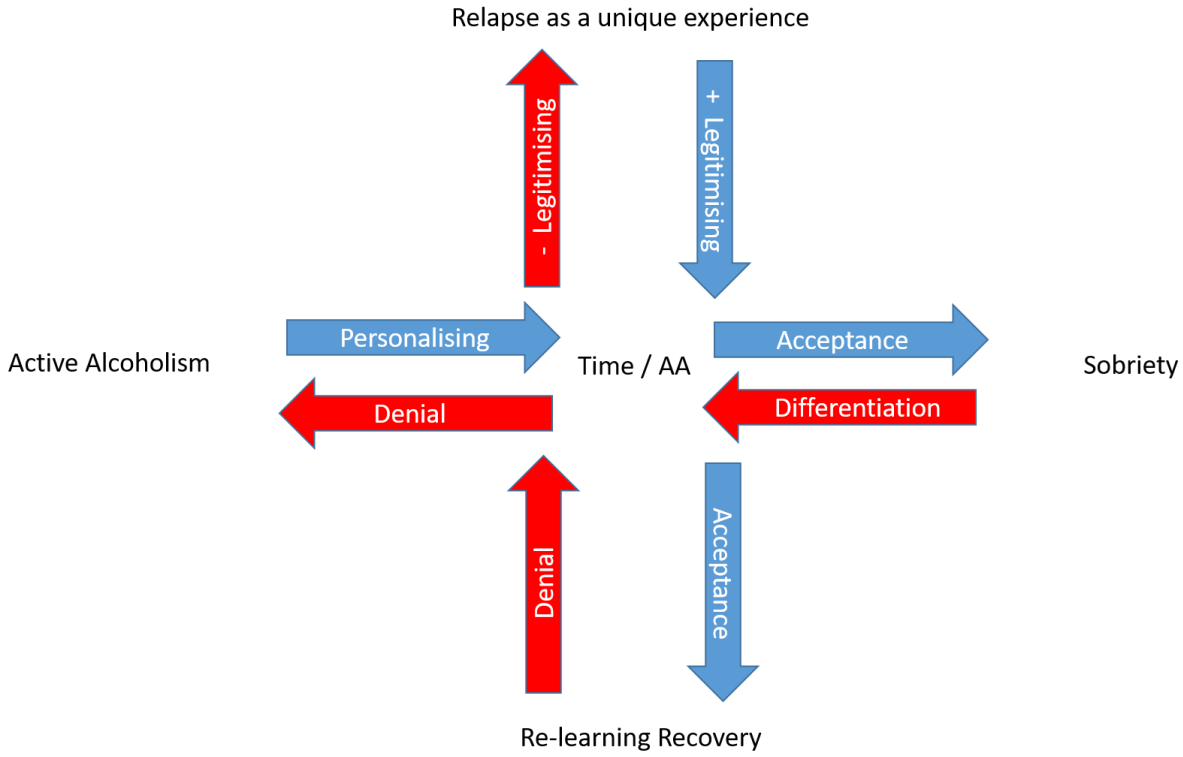
P1: I had to relapse to get to where I am. I have to do that now, in hindsight... I can't, I couldn't have thought about it after being sober for 7-8 weeks to think that what I need to do is go and get drunk again. What I had to do is legit... legitimise that in hindsight to think, well I suppose if that was my end-game that was the thing that I needed to do to find sobriety today, to find how bad it was or how bad it could be again, um,...

R: So that kind of proved it to yourself...?

P1: Yeah, yeah. But that isn't, that isn't good thinking, it's the only way I can make it right in my head that there was a reason why that happened and I had to go through all that pain again to understand how bad it could be. And that is not good thinking and I accept that, but for me, that's fine and I can deal with it." (P1: 220-235)

The model, therefore, now looks as follows:

Figure 6:



The processes of *personalising* and *positive legitimising* are not mutually exclusive, but complimentary and developmental. *Personalising* is an on-going process of positive self-development and self-awareness as an alcoholic acquires, during his or her recovery, those subjectively preferred dispositional qualities or traits of character (notably humility and acceptance), necessary to the formation of an autonomous way-of-being which delineates him or her as being *in recovery*. *Positive legitimising* is the re-appraisal of an historical act, (i.e. the consumption of alcohol) which took place at a particular time and place and is now viewed as being unhelpful. As the personalising nature of his or her recovery, binds him/her ever closer to this new way of life, so an ASR can revisit the act of relapse (as s/he does within these interviews) and so re-appraise the negative experiences of relapse (e.g. fear) in the light of his/her current recovery (e.g. gratitude):

"P5: I will never ever feel complacent I don't think again about my recovery, I will never think I have it, I've got it, um, I'm happy in my recovery, I'm carefree in my recovery, I love my recovery, why would I want to go back now? I think I have to have a picture not only of how awful it was in my head, but how good it is now in my head so that I've got those two, er, two things as a as a thing to keep there... rather than just having the

awfulness of, of what to relapse would be like, I need to have the, the amazing life that I have now in, in my head." (P5: 313-320)

Relapse has taught an ASR's that s/he can up-end this process quite easily, by convincing him/herself (*negative legitimising*) that s/he is still safe to consume alcohol and remain in control of whatever the outcome might be. The act of relapse is perceived not as the consumption of a beverage *per se*, but as the gradual, antecedent cognitive processes which anticipate the act of drinking, by a self-persuasive process of denial which effectively states, "I am not an alcoholic; I can drink safely"; relapses are planned events. Importantly, this process of self-persuasive denial can take months even years to develop. The *positive legitimising* process (which it is accepted may not make sense of the totality of the experience) serves to remind an individual of the baffling nature of relapse, the power of the obsession and compulsion to drink and the dangers which await him/her if s/he yields to temptation. Personalising draws an ASR forward to perpetuate the act of recovery, whereas *positive legitimising* motivates him/her to avoid all contact with alcohol (wherever possible) and so develop, *inter alia*, those idiosyncratic strategies of attenuation which keep him/her safe.

If their (personalised) new way-of-being is guided by AA's 12-Step philosophy, then it is also enhanced by the experiences of both those who have secured lasting, effective states-of-being (recovery), as well as those who have chosen to forget their identity as recovering-alcoholics and have elected, once again, to drink. In some cases the salutary lesson learned is that such people die. The nature of alcoholism is believed to be the fact that people will choose to forget that they are alcoholic but, erroneously, trust in their own self-agency:

"P3: ... I can trust the people in AA who have recovery and recovery isn't the fact that they have been sober for year after year after year, recovery is the fact that they understand that their life is better without alcohol. That may mean that their recovery has periods of relapse, that's the nature of the illness, but unfortunately, people who even have a strong recovery may relapse... [alcoholism] it's an illness, a parasitic illness if you want to call it that and but it's also a terminal illness and allowed to run its course it will kill us and that's what I see when I see someone who has relapsed and doesn't return to AA,(pause) my fear for them is that this illness will kill them." (P3: 310-322)

If an ASR oscillates, moment-by-moment between the states of active-alcoholism and sobriety, along the horizontal axis of the model, s/he can equally oscillate along the vertical axis. This is because, as a learning experience, the process of relapse may sometimes fail to convince him or her that the lessons to be learned from it necessitate profound personality change. In this case, even though the evidentiary experience of relapse would plainly imply that alcoholism is causing problems, an individual will continue to drink. An example of this is provided by P1 who helps a particular individual who has relapsed, "*there's a gentleman, er, who has relapsed 4 or 5 times*" (P1: 664).

To complete the model, account has to be taken of two further phenomenological themes of process, emerging from the study, which are *choice* and-*will power*. *Choice*, in terms of exercising a volitional decision to take one course of action versus another or whether the consumption of alcohol can be deemed to be nothing more than a lifestyle choice or exercise of free-will, is a vexatious question within these transcripts which is never fully answered. P1 refers to the conventionally held wisdom that drinking is nothing more than the exercise of personal-choice but that, in his case, this was somehow denied to him:

"P1: I mean most, from an outsider looking in most people think it's a choice and I didn't have the choice, that's how it was for me. I didn't have a choice." (P1: 602-604)

P3, whilst referring to alcohol as his "*drug of choice*" (P3: 34), similarly links the notion of choice to the idea of personal control:

"P3: The relapse was at a point when I had got those drinks but it was inevitable, there was no other option, I was going to open them cans.

R: You had no choice?

P3: There was no, it wasn't in my control at all. It was going to happen." (P3: 44-48)

Personal control is associated with the construct of self-efficacy, a term used within the psychosocial field to mean an individual's ability to make volitional decisions, in this case an individual's belief in his or her ability to refrain from consumption or not

as s/he chooses. Self-efficacy is trusting in one's own conscious, social and morally responsible decision-making process. It acknowledges that, in certain circumstances, an act of spontaneous self-will may need to be restrained or inhibited for reasons contrary to the nature, habit or desire of an individual (e.g. not smoking in a public building) but that this causes no lasting discomfort and can be adhered to.

Self-efficacy also carries with it notions of social responsibility and a conscious awareness of the impact of one's actions on others which will be taken into consideration when analysing the act to be performed. Self-efficacy is not some matter of arbitrary caprice, but entails empathy with an individual's social, legal, religious duties. Self-efficacy may, therefore, be linked to the idea of citizenship and it is the development of self-efficacy to which modalities such as the Relapse Prevention Model (Marlatt and Gordon, 1985) refer to and strive for.

In the struggle to understand this concept P1 alludes, metaphorically, to the complete absence of self-efficacy or personal control as being akin to a switch ("*something had switched on or switched it, or switched off..."* P1: 614) whereas, P3 prefers to describe it as being at the mercy of some, "*mysterious force*" (P3: 26). On the other hand, P6 takes a wider perspective, suggesting that in some cases he could exercise choice, but links the expression of choice as being firmly associated with the mental obsession that comes with his active-alcoholism:

"P6: I believe, somebody who is addicted, who has no choice, no personal choice over, over it is one way of looking at it and the wider way that I've come to look at it, is that alcohol was a problem for me, it caused problems in my life that I can now see more clearly but I, I was addicted, I was obsessed..." (P6: 173-176)

If relapse, as an expression of volitional decision-making, occurs outside the control of a person, then this is denied by P4 who is explicit when he affirms:

"P4: ... relapse, slip, call it what you will, it's and in my experience they have always, (hits table with hand), always (hits table again) been planned. I, I I've never met anybody and they've said to me that on impulse I, I reached out picked up someone else's drink or a drink that I saw on a table and just drank it..." (P4: 446-449)

Yet this is precisely what P2 claims happened in her case:

"P2: ... without a thought I picked that glass up and drank it..." (P2: 25-26)

P5, on the other hand, was fully aware that she was going to relapse when she boarded a train:

"P5: ... so the relapse actually I sort of planned my train journey to(names place) when I knew I would be totally alone and that nobody need ever know." (P5: 20-21)

In the time before the actual ingestion of alcohol takes place (which can be days, weeks or even a split second), an alcoholic comes to a decision to drink and executes that decision, so that the act of consumption is apparently, a deliberate act of free-will. What is not chosen, or at least is not anticipated, is that what will then arise will be problematic. This is because an individual believes (or chooses to believe) that somehow the outcome of events can be controlled by him/her in some way. P2's whose relapse happened "*without a thought*", even though she acknowledged that she was alcoholic, still believed that, *"…I bet I could have a drink and never want another one again...." (P2: 191-192)*

There is a strong nexus between freedom of choice and the corresponding notions of control. In other words, if an alcoholic believes that s/he can exercise self-efficacy and is master (or mistress) of events whether this is after consumption has begun or that s/he can, single-handedly, subdue urges and temptations to drink before consumption commences and do so un-aided, which may be termed "*willpower*" (P6: 199) or "*fighting*" (P1: 435), then s/he runs the risk of relapse, if s/he is alcoholic. The reason for this is that a person is not thinking like an alcoholic-in-recovery. For an alcoholic to think that s/he can exercise control, or self-efficacy, is an indication that s/he is already moving towards a cognitive frame of relapse. An alcoholic-in-recovery recognises or accepts that, as an alcoholic, s/he can never rely on self-efficacy; in the past s/he has tried and failed. For example:

"P1: ... I'd been fighting, er, to keep sober whereas I said I won't have a drink, I won't have a drink, I won't have a drink, I definitely won't have a drink, I won't have a drink and I always ended up drinking." (P1: 435-436)

If a new way of construing alcoholism is not achieved, then a person will always interpret relapse in terms of the need to apply self-control/will/efficacy because their thinking is in tune with active-alcoholism.

P1, P3 and P6 give examples of this. In trying to get sober, life was a daily "*fight*" (P1: 435); "*battling*" (P3: 17) or "*confronting*" (P6: 201) which involved the gritted-teeth determination to attempt to resist all urges to drink. This "*head-on approach*," as P6 terms it (P6: 203), fails because it relies on willpower alone. Over time, the sheer physical and mental effort at trying to resist temptation wears a person down to the extent that, finally, s/he succumbs and relapses:

"P6: ... I didn't approach it in that direct way of, of, of of confronting it head on and and with the front of my mind consciously sitting there and trying not to drink and being you know, this head-on approach of trying to stop and using willpower to stop, didn't work that's why I couldn't cut back..." (P6: 201-204)

The decision-making process of relapse is seldom made openly and so subject to the critical gaze of others. For those who are attending AA, this is because not only family, but other members of AA, would actively seek to dissuade them from their intended choice of action. P4 suggests this when he says:

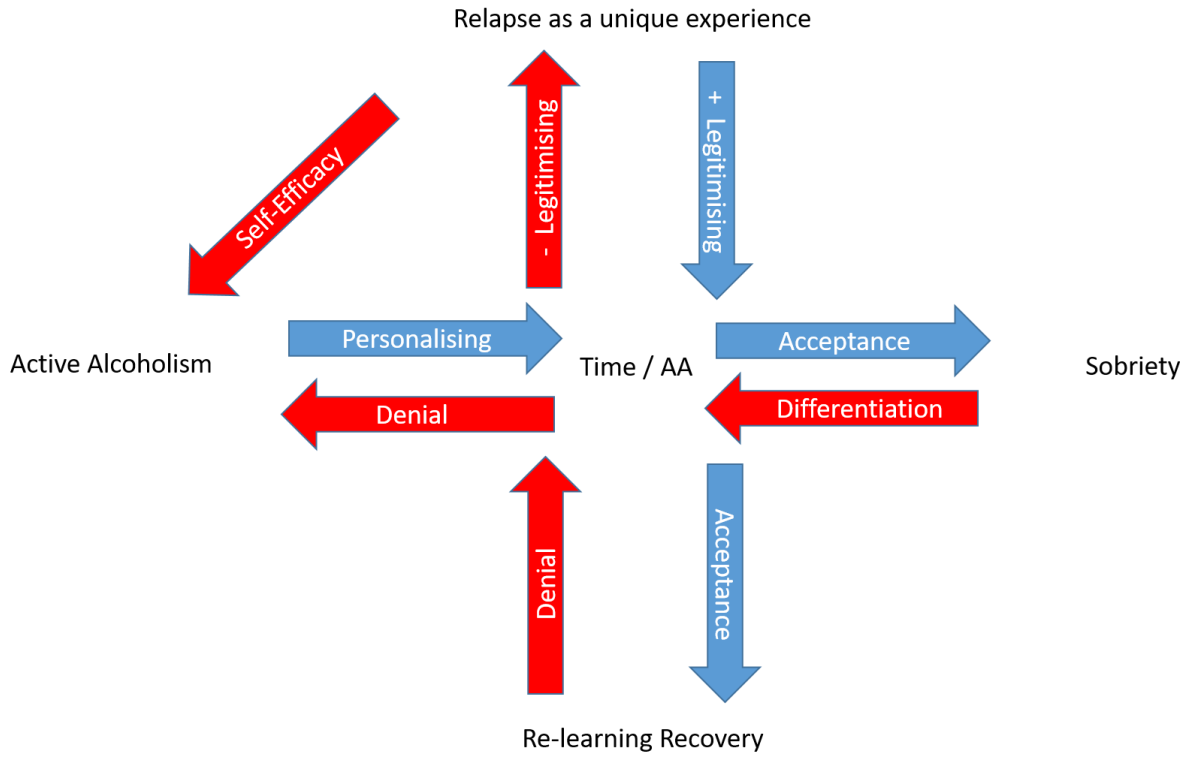
"P4: If I'd have said to someone look this is... these thoughts [to drink] are going through my head, this is my thought process the deadline is the 25th or whatever that's when my wife goes away, what do you think, I mean I, I know what would have happened somebody would have said well "Come with me to a meeting on the 25th or come and have tea with me on the 25th, let's go and have a coffee... but I, I wasn't in the frame of mind to be that honest at that point... I was still wanting to be driving the bus you know I wanted to be in control of my own...destiny, I wasn't ready to open up..." (P4: 248-260)

Instead, an active-alcoholic isolates him/herself from others, refuses to share his/her thinking-process and, lacking in open-mindedness and honesty to ask for help, elects to rely on his or her own belief in personal efficacy in the belief that s/he can "*handle*" it (P1: 506). If this historical belief in self-efficacy prevails, then this same attitude will apply to the processing of a relapse experience. What relapse, hopefully, teaches is

that self-efficacy does not work, being a distortion, in person-centred terms, of the self-concept. *Inter alia*, it further teaches the need for developing interpersonal relationships with those empathic to the condition. It is to this that P1 refers when he talks about the "*old rules of how you live*" (P1: 547), or as P4 describes it as being an example of "*old thinking*" or the prevalence of "*old character traits*" (P4: 486). It is the presence of shared phenomenological experience, within the mutual-help group of AA, which reminds an individual and helps restore a person's contact with the phenomenological reality of how AA perceives alcoholism and which, prior to relapse, s/he has agreed, congruently, matches his/her experience (Kelly et al., 2009; Kelly et al., 2011).

Self-efficacy (i.e. the belief in personal control and the exercise of willpower and isolation from others), which the interpersonal phenomenology of the AA group helps militate against, can now be added to the model, thus:

Figure 7:



The belief in *self-efficacy* as shown in the model (top left) may designate relapse as being a unique experience, but prevents an individual from learning from that experience. Stress, negative-affect, temptations and urges may all put pressure on an

alcoholic towards wanting to drink; this applies to the sober as well as to the non-sober alcoholic. But, if s/he believes that s/he can control the outcome of a relapse or inhibit the volume consumed once drinking has begun, then the likelihood that relapse will occur is much greater, as eventually this self-belief will be put to the test and, as was found by the participants, will be found wanting.

The counter-balance to the negative influence of self-efficacy is the positive benison of *autonomy*. Autonomy is a collective construct, or super-inordinate theme which includes the sub-themes of acceptance, humility, self-awareness, gratitude, spirituality and a wide range of positive attributes and dispositions which affect an ASR who now thinks and behaves as one *being-in-recovery*. Paradoxically, autonomy appears to consist of an individual accepting the limitations of the self, in this one area of being, but who realises the significance of sacrificing the desire to drink in order to unlock his/her full (and possibly unrealised) potentiality. Autonomy, therefore, can be said to derive from the spiritual awakening foretold in the 12-Steps and is the gradual development of an acceptable or satisfactory quality-of-life (sobriety) achieved through an appropriate means (recovery) suited to an ASR's individual needs.

An ASR is one who thinks and acts as one in recovery and chooses to do so, because the sense of well-being that a recovering life unleashes is infinitely better than any experience of living that s/he may have, heretofore, known. An example of this is provided by P6 who chooses to engage with the 12-Steps, not because it is the right thing to do, but because he anticipates that his spiritual life will be the better for it, "*I quite like the idea of that*" (P6: 324). Another example is provided by P1, who acknowledges that he is in recovery and, in many ways, has achieved a significant goal in his life. But, he engages with acts of selfless altruism (not because of some moral mandate) but because, "*I'd still have recovery but it wouldn't be as big, or full, or rounded*..." (P1: 626).

Autonomy brings with it subjective feelings of contentment, ease of conscience and inner calm; "*I'm happy in my recovery, I'm carefree in my recovery, I love my recovery, why would I want to go back now?"* (P5: 315-316). Autonomy also represents the true experience of freedom. An ASR lives as s/he does, not because s/he necessarily has to, but because this new way-of-being is so conducive to him/her. It is now that not only do the curious expressions of gratitude for having relapsed emerge:

"P4: ... in some ways I'm happy that I relapsed in the fashion that I did, I mean, I'm not happy that I relapsed, but, but I think it's probably necessary for me to sit down and have a hard look at myself..." (P4: 393-395)

but there is also a sense of pride in overcoming such a life-threatening and destructive illness:

"P6: I am quite, I in some ways I am proud of myself for having and there is a sin of pride, but I am, um, proud of myself for recognising that I am alcoholic and being prepared to deal with it and, um, yeah, it's that acceptance that's what I am." (P6: 265-267)

The sense of personal pride was echoed in P5's validation interview, who used the word "*proud*", in reference to herself, four times:

"P5VT: ... I'm proud to be an alcoholic...

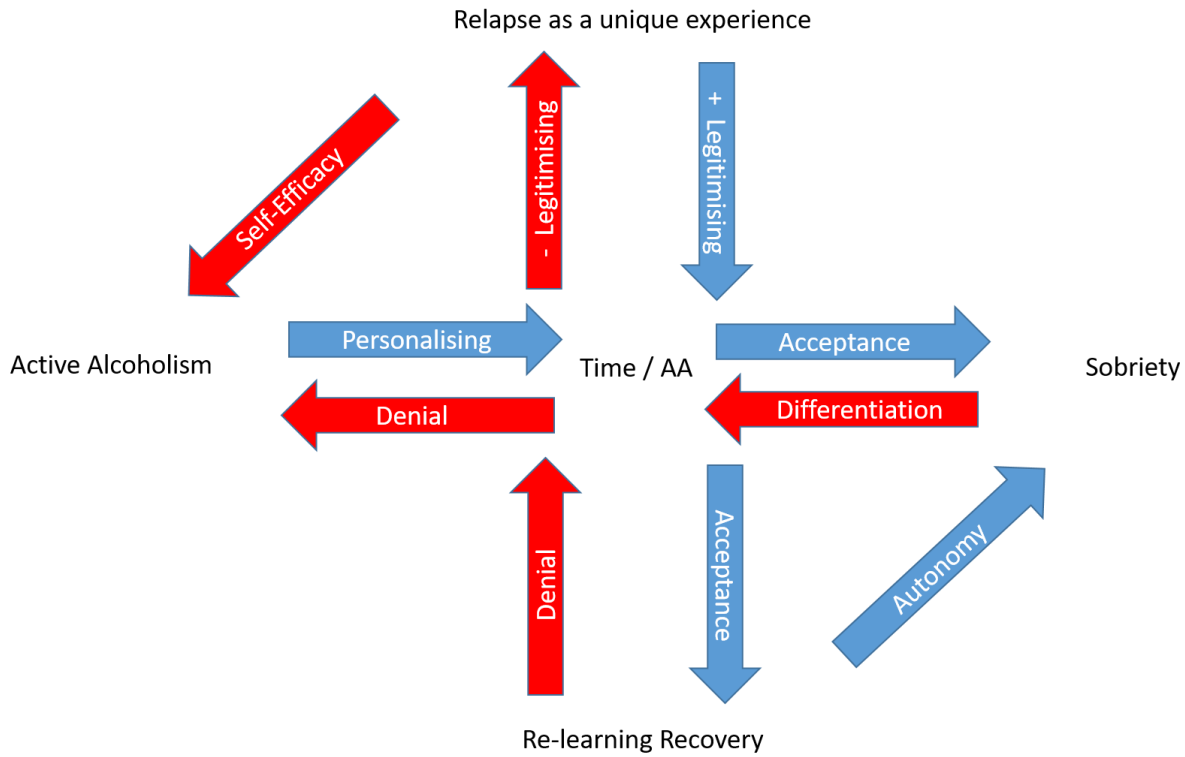
R: Right.

P5: ... I am proud to be a non-drinking alcoholic that's, that's one issue, the other issue is that in a sense if I, I say that I'm an alcoholic in a, in a a, er, a party of something where the people don't know me and they don't know anything, I am putting it on the table as a a defence... "(P5VT: 262-267)

It is an achievement not only to throw off the burdensome yoke of active-alcoholism, but the fact still remains that despite all that has been achieved, an ASR has still to consider him/herself, in part, a wounded soul. S/he will continue to label him/herself alcoholic, long after s/he has achieved years of non-drinking. But it is a misconception by those who view AA as holding an inherently negative or pathological view of the human condition, which fails to recognise the sense of liberation which ASR's experience. They do not reify their condition to a sub-set of typologies or view themselves as being defective or even vulnerable. They recognise their limitation in one area of functioning, but in accepting that self-imposed restriction, they are now at liberty to explore the fullest nature of their potential.

The model can thus be completed:

Figure 8:



The pathway to sustained sobriety comes through an accurate assessment (e.g. the moral inventory of Step 4) of an individual's character with a view to gaining a congruent understanding of the self as a fully-functioning citizen. It is more than staying sober. Sobriety, as a quality-of-life, is a fluid construct which evolves through the life-span of an individual. The development of autonomy is the growing appreciation of what is meant by the process of recovery and how it will achieve the life-goals which a person desires. The declaration of powerlessness and unmanageability, required in Step 1 of AA's 12-Step programme, is an act of empowerment (i.e. abandoning the illusion that they can "control" their drinking). This leads to the development of congruent self-awareness and self-knowledge, where knowledge becomes power and a person resumes responsibility/agency for his/her own life and actions. One aspect of this responsibility is the need to remain sober:

"P3: ... keeping away from that first drink is my responsibility and it's something that I do consciously all the time..." (P3: 179-180)

AA's Steps 2 and 3 recognise the concept of *surrender to win*, so that a person, significantly, increases his/her own agency, control of self, self-acceptance and

personal esteem. Above all, relapse teaches or reminds an ASR that s/he is alcoholic. The process of this awareness may change over time. Initially, the simple fear of not wanting to relapse, acts as a motivator to stay sober. There may even be, as P6 discovers, a genuine surprise that being sober, one day after another, is possible:

"P6: ... my alcoholism as an obsession, a mental obsession and, um, that lifted for me relatively easily and I felt guilty about that, I felt guilty that it had gone so easily because I thought well you should have been able to do this and lapsed back into this way of thinking that it's a matter of willpower..." (P6: 197-199)

All his efforts at trying to justify his drinking behaviour were fruitless and "*farcical*" (P6: 107). As sobriety develops and, along with that change, the method of recovery evolves, positive sensations of gratitude begin to emerge as negative feelings gradually abate. The art of sobriety is to adapt to a form of recovery which keeps these two polar ends of the spectrum in clear view. As P5 states:

"P5: I'm happy in my recovery, I'm carefree in my recovery, I love my recovery, why would I want to go back now? I think I have to have a picture not only of how awful it was in my head, but how good it is now in my head so that I've got those two, er, two things as a as a thing to keep there...

R: Yeah.

P5: ...rather than just having the awfulness of, of what to relapse would be like, I need to have the, the amazing life that I have now in, in my head." (P5: 315-320)

12.3 Chapter Summary

In proposing a person-centred clinical model which serves to summarise this study's findings, it has been possible to evidence, diagrammatically, the fluidity of the opposing processes of both active-recovery and active-alcoholism and the rôle which relapse plays within them, from the participants' frame-of-reference. In revealing these processes by which ASR's, congruently, incorporate experiences of relapse into a recovery-oriented self-construct, I have attempted to pay close attention to the expressiveness of their narrative descriptions whilst displaying a lightness of touch as

regards interpretation which has been, as far as is practicable, validated by them. I have illustrated their phenomenological understanding of relapse/alcoholism through an extensive use of, in *vivo,* quotes.

As is, perhaps, suggested by their contemporary life-stories, the daily process of recovery, *post-relapse*, involves maintaining sobriety and is recognised by them as a moment-by-moment process of oscillation between different contexts, moods or temporal states, environments and challenges, of varying degrees of risk, encountered within the course of a natural day. Over time, the task for an individual in recovery is to find a *via media* which maintains a stability of mood, physical and psychological health, so that alcohol-use does not appear relevant to manage quotidian existential challenges. This differs from person-to-person.

The clinical model illustrates a dichotomy between an admission of reduced self-efficacy in one specific area of functioning and the countervailing effect of autonomy which influences not only the transition from active-alcoholism to recovery, but the processes by which recovery is maintained over time and through the operant therapeutic factors of AA. Relapse, i.e. the use of any alcoholic beverage of any quantity, ignores the basic principle which for years, whilst in active-alcoholism, an ASR has tried to deny which is that, as an alcoholic, s/he can exercise no self-agency in his/her defence against it.

The expectancy that alcohol will bring immediate relief is well founded on experience, but what is continually ignored, within the relapse process, is that the consequences of such thinking and behaving, like one in active-alcoholism, will inevitably be traumatic. In other words, to think that drinking alcohol is an option is to think like an active-alcoholic and is inimical to the thought processes of one who is in active-recovery. Relapse swings the pendulum back towards active-alcoholism. Alcoholics can, once again, justify actions taken in an act of negative legitimising, characterised by seeing themselves as being different from others who share the same condition.

Alternatively, relapse can be used positively as being a unique experience, which teaches an alcoholic a valuable lesson; s/he cannot rely on willpower or self-efficacy. Ideally, this can be done only once, as the danger of multiple relapses could be fatal but indicates that s/he has not formed a congruent self-concept as, each time s/he

relapses, s/he demonstrates that s/he still retains some notion of personal control which, in AA terms, has to be eliminated from the phenomenological self-construct of an ASR.

Instead, relapse teaches the need for abstinence and affiliation with other like-minded individuals who are ready and willing to assist when problems are encountered and long before alcohol is consumed. AA, with its interpersonal phenomenological understanding of both alcoholism and what it means to be alcoholic, acts as a mediating influence where the varied experiences of each member serves to add to the aggregate understanding of the phenomena and so that all are prized.

Paradoxically, relapse, provided that abstinence is the intended outcome, can be legitimised (positively) as an experience worth having. It dispels, however, personal myths about self-efficacy, self-control but not of agency; relapse is volitional. By accepting the status of one who is alcoholic, an individual embarks, through AA and following its precepts, on building a form of practical recovery which enables a state of well-being or quality-of-life (termed *sobriety*) to emerge. In doing so s/he assumes personal moral responsibility for any consumption of intoxicants.

But, in choosing to live a sober lifestyle, which involves recognising this single limitation of self, an ASR unlocks his or her potential to become a fully-functioning human being. Recovery becomes a journey in learning about the self:

"P3: ... because I'm sober and I continue that process through the day. I, (pauses, sighs), I learn more about myself and the more I learn about myself the more comfortable I feel about myself..." (P3: 162-163)

Being sober becomes more than a conscious choice but a way-of-living, autonomously made, because of the heightened benefits of living free from the negative consequences and obsessive feelings and thoughts surrounding active-alcoholism. AA (1976) promises that the spiritual lifestyle of sobriety is a journey beyond the wildest imaginings of an individual, as s/he moves, daily, towards new heights of positive experiencing untrammelled by his/her old, restrictive, alcoholic self.

The next chapter examines the limitations of this study.

13.0 Chapter Thirteen: Considerations

The study's limitations are set out below. These comprise: sample size; the validity of self-report; the influence of AA in shaping narrative descriptions; the restrictive nature of semi-structured questions; the reliability of participant-validation; the ability of the PCA to deliver reliability, dependability and validity; and the problems of reportage caused through the limitations of the word-count. This chapter concludes with a reflexive statement on my learning experience derived from the PhD process.

13.1 The PCA as a research method

By employing the PCA in the study of alcoholism/relapse, I endeavoured to create evocative, true-to-life and meaningful portraits of human experience (Sandelowski, 1993). I was not seeking to derive causal explanations or theoretical conclusions for relapse, nor intending that my findings were transferable outside this study cohort. Without being overly interpretative, my study aimed to view, through the lens of their frame-of-reference, the subjective accounts and personal experiences of relapse from an otherwise neglected study group within the ATRF. In helping provide a more detailed picture of relapse in an area where there is currently scant knowledge (Stiles, 1993), I was responding to requests, within psychotherapeutic research, from those who argue for the inclusion of a client's perspective (Townend and Braithwaite, 2002).

I acknowledge that the PCA, unlike IPA or Grounded Theory, is not located within the mainstream of ATRF research methodologies (Hycner, 1985) and though offering a methodological framework for research with techniques for its conduct (Mearns and McLeod, 1984) remains, relatively, unproven (Given, 2008). Yet, as a participatory and collaborative method of understanding experience, it encourages participants to perceive not only that they are being listened to but, by employing certain qualities and conditions which enhance any interpersonal encounter (Buber, 1958/2000), enables them to describe their unique experiences with enhanced congruence (Rogers, 1951). It pays attention to the phenomenology of experience, but in eschewing researcher-driven data-reduction and interpretation of themes, which can be translated into therapeutic interventions, it does not compare with the traditional analytical interpretation of phenomenological research.

13.2 Sample size

My ethical proposal required an *a priori* indication of sample size (Cheek, 2000). With research guidance on an optimum number for this style of study being inconclusive (Guest et al., 2006) this was, originally, determined at 9-12 participants and was reviewed during the study as suggested by Tuckett (2004). AA is a closed community and recruitment proved difficult. Utilising a purposive set of selection criteria to reduce potentially confounding variables (Palys, 2008) further restricted the diversity of the participants available and so raises the question of how representative of the general population of AA members my sample might be? However, a detailed focus on a small number of participants made possible a close and extensive examination of their experiential narratives and their attempts to make sense of their experiences and generalisablity was not an aim of my study.

Participants were not diagnostically assessed but self-labelled as being alcoholic. Their experiential narrative-descriptions indicated that each was (and believed him/herself to be) at the far end of the continuum of alcohol severity (Sanchez-Craig, 1986); collateral or objective verification of this positioning was unavailable.

The particularities of this study being local to my place of work and domicile may reduce transferability to other settings. Participants were drawn from a defined geographical locale within the North West of England; their median age was 59.6 years; they were all married, white, middle-class and Caucasian; if practising any religion this was stated as Christian. Three participants (all male) had received professional help, one privately (P4), one NHS-based (P6) and one indeterminate (P3). Absent from the study were men or women who were homeless, unemployed or otherwise disenfranchised.

I was unable, therefore, to determine the effects of ethnicity or wider socio-economic effects on their narratives and the gender-bias of the study was weighted towards male participants. This was not intentional, but was affected by recruitment difficulties, which were unforeseen and outside of my control. Nevertheless, my study does have a restricted cultural context. I did not synthesise nor conflate the experiences of men and women, to provide a general explanation of experience, as each narrative was addressed as a unique entity.

The ages of the participants ranging from 42-72 were not reflective of a younger age group. However, the acquisition of alcoholism may take some considerable time within the lifespan of a person (Edwards and Gross, 1976) so that the exposure to AA may be a lengthy process (as suggested by P4) before its beneficial effects are noted (Glaser and Ogborne, 1982).

My study deliberately limited itself to alcoholics adhering to the ideology of AA and being unaffected by such confounding variables of comorbidity (e.g. psychological problems or poly-drug use), which may have brought additional pressures to bear on an individual, thereby precipitating relapse and hampering the future securement of sustainable-recovery. Each participant had relapsed, but now enjoyed a minimum of two year's sobriety. Some narratives referenced AA affiliates who had relapsed several times, so that my study's participants may have been the exception rather than the rule, whereby AA members may frequently cycle in an out of recovery, as suggested by Hoffmann (2003).

Additionally, these participants were willing to share their experiences and so may have been highly motivated within their recovery (Cunningham at al., 1994). A comparison with participants, of corresponding severity, drawn from different backgrounds, ages, or different recovery pathways, may have been useful.

13.3 Self-report

I treated each participant's narrative as being reliable and accurate (allowing for distortions of memory). Yet I acknowledge the ATRF's running debate, regarding the reliability of retrospective self-report, where the narrator is both actor/observer of what s/he describes (Seneviratne and Saunders, 2000). Personal narratives may be viewed as unreliable (Sharpe, 2001), where reported details do not always correspond with actual events (Rohsenow and Monti, 1999), consequently necessitating collateral verification (Maisto and Connors, 1990). Although external verification was not available to this study, I suggest that it may be foolhardy to apply conclusions drawn from in-patient research as being applicable to those in longer-term recovery. It is possible that after a period of time a person may recall the temporal flow of events which preceded a relapse but cannot, necessarily, establish whether a particular

antecedent was causally linked to it or whether it was triggered by events which substantially predated it (Miller et al., 1996).

The validity of self-report may be affected by gender, where women tend to report less positive experiences and more unpleasant affect and interpersonal problems (McKay et al., 1999), whereas men report more positive mood-states (Rubin et al., 1996). Self-reported narratives can also be affected by the mood-state of a person, (physical, emotional and psychological) at the time of an interview (Hodgins et al., 1995).

Self-report without collateral verification may be a limitation to this study, though other studies, e.g. Sobell and Sobell, (1978) supported by Thoreson, et al., (1986) indicate that uncorroborated self-report shows moderate to strong validity. Denzin (2009) suggests that, within AA, incentives to mask relapse or distort the truth about urges to drink are largely absent. My study's participants were not being encouraged to disclose potentially new information about their historic rates of alcohol consumption or recent, problematic events which they, currently, needed to address. The narratives were exclusively subjective accounts of past events, which had implications for the present.

Being retrospective, they may have been, negatively, subject to distortions or amendment based on memory-loss and selective recall (Connors et al., 1988). Positively, they may have been subject to revision in the light of a developing sense of recovery whereby that which, at the time (and influenced by alcohol consumption) was important may, over time, have lost some of its causal salience. I am not suggesting that narratives were deliberately falsified (Bergmark and Oscarsson, 1987), but they were recognised as retrospective interpretations, by the narrators, of what they felt relevant and, importantly what they were comfortable in disclosing to a researcher.

Another factor conditioning self-report is an individual's defensiveness, given that they are describing events and behaviours which are not valued by society (Cloninger, 1987) and have no knowledge, therefore, of the response which may be provoked within the listener. The use of the PCA meant that narratives were heard in a non-judgemental way (Mearns and McLeod, 1984). Nonetheless, self-reported narratives, though a

conflation of various experiences, are a primary source of information for clinicians and researchers, which vary from person-to-person (Del Boca and Noll, 2000).

There was no evidence that reported details were being deliberately modified (beyond the distortions of memory), so that the narratives were treated as reliable and veridical, especially as all participants were alcohol-free and had been provided with the assurance of confidentiality (Connors and Maisto, 2003). Self-report, being subjective, produces narratives replete with bias and interpretation rather than accurate evocations of past events yet, for clinical or research purposes, abandoning self-report is both impractical and unfeasible (Hammersley, 1994).

The ATRF's debate over the validity of self-report is conditioned, I suggest, by its study of alcoholics whilst still in treatment, the implication being that, at this early stage, it necessitates the diagnostic expertise of professional clinicians to bring clarity to the available data. I accept that recovery-narratives appear to be affected by the (now sober) sense-making processes of those in recovery, as they struggled to reconcile aspects of their past which appear baffling in the present. But to continue to afford dominance to the researcher's rôle as principal sense-maker (years after a person has secured recovery) is, perhaps, to denigrate the agency of an individual's ability to self-actualise and describe their own phenomenological field as they, currently, perceive it.

Memory is not to be treated as a passive storehouse of information which can only be, convincingly, explained by a researcher. It serves as a set of active functions for learning, to do things and deal effectively with the world which, in this case, was to live as recovering-alcoholics; it is a complete self-convincing experience (Hammersley, 1994). I was sensitive to the fact that not everyone had full introspective access to their psychological processes which could have been distorted, *inter alia*, by alcoholism.

13.4 The Influence of AA

The ATRF argues that AA compels a person to follow, unquestioningly, its precepts and so fails to account for the individuality of a person (Ellis and Velten, 1992). Another potentially limiting factor could be that individual narratives may have been unduly

influenced by an affiliation with AA. However, describing relapse by an overtly AA-narrative type would have been compatible with this study, if it were clear that this was a deeply held conviction of how a person chose to perceive the phenomenon of relapse.

The frequent references to AA literature, primarily *The Big Book*, (AA, 1976) and its 12-Step Programme suggested that a participants' experiences were (post-relapse) being harmonised, to some extent, with AA philosophy. But this was in line with the research question, which sought to elicit the perceptions of relapse *by AA members*. The telling of the life-narrative serves many purposes within AA, not least of which is to confirm a member's self-formation and conformity to the community's ideals (Travis, 2009). AA affiliation undoubtedly plays some rôle in shaping a recovering alcoholic's attitudes and beliefs, but the narratives within this study suggest that this influence should not be overstated and that understanding relapse and developing a means of recovery is more complex than simply being told what to do. Instead, each person created a story which matched their own experience and did not comply, blindly, with some pre-existing AA narrative model.

Unlike Moos (2007, 2008) I am not suggesting that AA exerts some form of social-control over its members. However, narratives may reflect a shared identity as being *recovering-alcoholics*, which may extend to the acquisition of a commonality of positive moral values, thoughts and behaviours (Galanter, 2014). My study examined the perceptions of relapse through the lens of an experience of recovery supported by AA membership. It was expected that the discourses would be, occasionally, reflective of its ideology. During the analytical process, to distinguish between descriptions which could be AA-derived versus personal reflections, attention was paid to metaphors which could be identified as AA derivatives compared with those which were eidetic and subjective.

For this purpose I accessed the web site which could retrieve AA's writings word-by-word: http://www.whytehouse.com/big_book_search/. Findings suggested that, whereas AA metaphors were confined to areas describing notions of powerlessness and unmanageability (drawn from Step 1), as well as constructs of alcoholism being a disease or illness, the use of AA metaphor was not significantly influential in shaping a

participant's narrative. The one exception to this rule was P1 which was accounted for by his particular view of AA.

Another aspect affecting the validity of self-report, stems from the participants' understanding of both confidentiality and anonymity. The group's title, *Alcoholics Anonymous*, hints darkly that alcoholics experience stigma (Kairouz and Dubé, 2000), therefore, anonymity is a central tenet of AA (Kassel and Wagner, 1993). Though assurances of confidentiality were given, participants may not have been willing to engage with a full disclosure of their experiences. An external threat to confidentiality, which arose unexpectedly, instantly halted the recruitment process. Nonetheless, the experiences described within my study were comparable with studies which cite the experience of active-alcoholism (e.g. Denzin, 1987; Addenbrooke, 2011) and so, overall, revealed no deliberate withholding of information.

13.5 Semi-Structured questions

Gryczynski, et al., (2015) suggest that the phrasing of research questions may impact on the data retrieved and the responses given. Whilst pre-prepared questions, presented before their initial interview, helped reduce participant anxiety and provided them with a forewarning of what was to be asked, they also served to direct a participant into describing his/her experiences in the context of the research's agenda and so could be viewed as directive (Ryan and Bernard, 2003). Employing semi-structured questions may, unwittingly, have narrowed the participants' repertoire of responses in important ways. Questions indicated, in advance, some of my interpretive bias, thereby supporting the argument that it is the researcher who knows best. Such questions demonstrate an unhealthy example of an imbalance of the power dynamic so central to the PCA's aim for equality (Rogers, 1951) and are incompatible with non-directive interviewing (Rogers, 1945).

I regret using semi-structured questions which, whilst helpful in securing the study's ethical approval, did not allow the interviews to be based, solely, on the participants' frame-of-reference and, potentially, influenced what they disclosed. They also demonstrated a fundamental lack of trust (even disrespect) for the participants' recognised abilities at story-telling (Rushing, 2008), as it implied that they might,

perhaps, be unable to create a narrative without prompting. I now believe that my study would have benefited from an unstructured approach, by inviting the participants to reveal what they thought germane to relapse from their experience and so have, independently, shaped their own discourse.

The questions caused an additional problem of immediately widening the scope of this enquiry, by requiring a participant to consider his/her method of recovery, rather than the experience of relapse itself. In effect, rather than bringing clarity to that which was being sought, semi-structured questions may have overloaded the participants with a request for extraneous details, to which they felt obliged to supply. They also generated a larger than expected volume of data which was difficult to manage. Semi-structured questions were overly directive and incompatible with the PCA (Rogers, 1945).

13.6 Use of participant-validation or member-checking

Though not universally regarded as welcome or necessary within phenomenological research (see Chapter 5), I deemed the use of participant-validation important to aid my study's credibility, i.e. to highlight that which could be demonstrated as true, valuable and believable (Morse, 1994). I felt it, ethically, necessary to indicate to each how his/her data was being used and, also, that his/her data was not being misrepresented. Primarily, it made the descriptive analysis transparent to the participants.

In turn, the PCA experiential practise of listening to the participants and reflecting back to them what each had said, was also made manifest and, hopefully, helped the research appear consistent, reliable and credible. It was not possible, however, to validate each descriptive analysis; one participant sadly died during the study and another fell seriously ill. I tried, nonetheless, to be transparent in terms of how I used the data and also by my use of reflexivity throughout the study (Merrick, 1999).

I recognised that participant-validation may not always be appropriate by reason of participant deference (Rennie, 1998); may evoke feelings which a participant would rather forget or cannot verify; or may overwhelm him/her with confusing detail due to

the difference between lay and scholarly synthesis and varying agendas (Sandelowski, 1993). The choice of whether to validate the descriptive analysis of their interview was an autonomous decision of each participant. Positively, its use indicated that the interview/research experience was found, unintentionally, to be therapeutically beneficial to those who took part (Chesler, 1991).

13.7 The use of the PCA: Questions of reliability, dependability and validity

By not following a mainstream ATRF research methodology, I ran the risk of not adhering to an accepted research pathway which can be scrutinised or benchmarked against comparable studies. The PCA does not consider itself to be a "science", even though, in this university, it is located within a scientific community which examines different claims to worthiness when compared with a psychotherapeutic approach. My findings are not necessarily replicable; my argument being that lived-experience is unique to an individual and not subject to a discoverable "essence" of what the phenomenon of relapse might be. Consequently, the description of a variety of relapse experiences is limitless and only constrained by the number of recovering alcoholics willing to discuss the topic (Wray et al., 2007).

Instead, being a practice-based study, I tried to address an area of knowledge and advance the ATRF's clinical understanding of relapse, as regards longer-term recovery, which was otherwise unknown (Stiles, 1993). The dependability of the participants' narratives is questionable, in so far as such discourses may change with time and circumstance and I am sanguine enough to realise that given different questions; with a different researcher; and on another day; or being in different mood-states might have produced different narratives (Lott, 1999). But, by using participant–validation, accepting of its inherent difficulties and limitations, I have tried to offer a representation of their thoughts and feelings (of the relapse-experience) as they perceived them and at the time and in the manner in which it was expressed to me but without undue interpretive interference. I acknowledge that each narrative was a revision/interpretation of experience, which may differ from the experiences as they occurred (Bleicher, 1980).

The validity of my findings is governed not only by the manner in which I have expressed them but by the fact that, at every stage of the process within my research, I aimed for transparency by submitting papers detailing my findings and conclusions to my supervisory team and clinical work-colleagues for scrutiny and review. This form of social-validation sought to ensure, as far as was practical, that I was working, congruently, within the parameters of the PCA and not subjecting my study to inductive reasoning which misrepresented the participants' narratives (Mishler, 1990).

13.8 Reporting the results

Every care was taken to seek external scrutiny of my findings (primarily via my supervisory team) to aid its trustworthiness; nevertheless, the study reflects the outcome of an encounter between one researcher and six participants. The order in which this study was conducted created some bias, as the literature search preceded the interviews so that, on reflection, the study, as a whole, was guided by *a priori* assumptions gleaned from the literature search (and my clinical practice). The concept of "bracketing" is wholly incompatible with the PCA's quality of congruence and how this is to be achieved, I find unintelligible and generally unexplained within research studies (e.g. Zakrzewski and Hector, 2004). In retrospect, it might have yielded different results, if the interviews had taken place first, making them the centrality of data acquisition, which then could have been compared with extant literature.

Reporting my study's findings required frequent illustrations using *in vivo* quotations, which is a wordy process (Morse, 1994). This enabled the study to *give voice* to the participants by quoting extensively from their narratives as it originally intended and so aided its methodological rigour, but produced a struggle with word limits. The transcript excerpts, being unfiltered, hopefully provide a persuasive quality which indicated that my descriptive analysis was close to the experiences of the narrators, conferring transparent plausibility.

But this also meant that some aspects of a participant's understanding of relapse (e.g. the application and rôle of the 12-Step programme or the processes of recovery) could not be described in more detail (Smith, 1998). Additionally, the study generated a large amount of data (in the form of notes, diary, reflexive essays and analysis of

different aspects of AA's philosophy and how it was operationalised), so that it was impossible to present, for scrutiny as an audit trail, the many written pages which could have illuminated my decision-making process throughout the study. Some of this material is included in the appendices (see particularly, Appendices 14 and 15).

However, it can be argued that the idea of such an audit trail is merely a disingenuous attempt at aiding the visibility of rigour (Smith, 1998). Whilst aiming to be true to the nature of the encounter between researcher and participant, I can only seek to offer a plausible, descriptive account of experience by referring to *in vivo* examples and illustrations. These were drawn from the verbatim transcripts, in order to make my case clear and its evidence manifest (Larkin and Griffiths, 2002).

The claim that my study sought to eschew interpretation has a Sisyphean quality. From the moment my research question began to form; my chosen method of approach to the subject; the selection of the research questions; the literature searches and their review; and the selection of which *in vivo* quotes to include, has all been a process of my decision-making. The PCA is phenomenological and set within the interpretivist paradigm, so that interpretation is inescapable despite my attempts to reduce its influence.

In their various ways these several points have all served to limit this study. How successful I have been in fulfilling my original aims and objectives is now, properly, left to the judgement of others.

13.9 How the PhD process affected my subjective learning experience.

I found the opportunity to witness and be offered a privileged insight into the process of recovery within the life of an alcoholic humbling, not only by reason of the relational depth at which complete strangers were prepared to offer descriptions of their life-experiences to me, but also as those experiences began to illuminate certain flaws of understanding within my clinical approach thereby highlighting a need for a change in my professional attitude. In other words, my study began within my clinical life (I did not know where it would take me as I had no pre-planned outcome, theory or

hypothesis for which I was aiming) and it is to that life (with reflexive modifications) that my study's findings now return. These I will describe below:-

In claiming to use a minimum of inductive interpretation, my primary concern within this study was my positioning as researcher/clinician in relation to the participants; these were not to be the usual rôles of PCA therapist/client. On the one hand, I would like to have seen the participants engage more fully with the study, effectively as co-writers within the analytical process, but I realised, from the pilot study, that this was ethically problematic as it would involve requiring more of their time than could be reasonably expected from them. On the other hand, I did not want to become the dominant force, particularly within the analytical process and, even though the PCA resides within an interpretivist paradigm, I hoped that such interpretation would not stray beyond that inherent in all human interacting (Worsley, 2002) and, consequently, not simply lead to pragmatic hypothesising. My principal criticism with ATRF research, which may profess a degree of "person-centeredness", is that it essentially allows the researcher to be the pre-eminent voice.

Though, at the time of writing, it was not a conscious thought, it was pointed out to me during my *viva* that I had, effectively, written myself out of the thesis as I sought to be guided by the participants as they described their experiences to me. In this sense, I was trying, even subconsciously, to serve as an amanuensis, faithfully noting down their life-stories for onward transmission/representation to a wider audience. This omission of self may have been avoided if I had followed a pluralistic methodology and, more formally and less apologetically, embraced the rôle of researcher/interpreter; however, I would still defend my application of the PCA on three grounds.

First, I was more competent within this approach to deliver a research study and was neither skilled nor trained in quantitative analysis. It is difficult, I suggest, to integrate other researcher epistemologies (e.g. which attribute elevated status to a researcher), with the PCA epistemology which seeks to equalise such a power imbalances and not run the risk of being accused of being pragmatically eclectic. As a person-centred therapist this went to the heart of my approach; could I, as Rogers (1957) suggests, be genuine, real, authentic or congruent, if I was following a research process with which I

felt uncomfortable or unqualified to fulfil? To act outside my competency was both unsafe practice and inauthentic.

Secondly, the intent of the PCA is to be lead by the participant and see the world "as if" through his/her expert eyes. This was an exploratory investigation into an area of knowledge about which the ATRF has no empirical understanding. It puzzles me why it appears to be acceptable, in all manner of research methodologies, to adopt a person-centred approach when interviewing participants, therefore, highlighting that they are being treated empathically and with respect but, at the moment of analysis, the PCA is abandoned as if trying to see the world through the participants' eyes and frames-of-reference is not fit for purpose.

There is no such thing as perfect research (McLeod, 2011) and non-directivity is a keystone of the PCA. On the one hand, it may be understandable when, as a PCA researcher, I made decisions or choices, for example in the temporal representation of a narrative, so that I am rightly hoisted by my own petard being accused of unsettling an inherent power imbalance, when the PCA's aim is to do the opposite. But the attributes found within the PCA (especially congruence) describe not merely a research process which is turned on and off by the research/practitioner as and when circumstance demands, but serve as "*an attitude, a state of being (and) a way of living*" (Wyatt, 2001: vii) which goes to the heart of who s/he is.

Thirdly, because of that exploratory status it was necessary, in this instance, to pay close heed to the participants' frame-of-reference and how they described their process of sustained recovery, recognising that the ATRF has failed to achieve this level of success. My aim, therefore, was to represent a full and accurately symbolised description of experience, hence my use of member-checking to confirm my findings. In all aspects of the research process the PCA strives endlessly, I suggest, to avoid researcher bias.

A legitimate question to ask is how has this process of research affected me and have, consequentially, my clinical attitudes changed as a result? I will summarise my response in five areas as regards my current understanding: of AA; of the process of recovery and relapse; of being alcoholic; as regard an ethical dilemma about recovering alcoholics themselves; and, finally, of me.

Of AA.

Originally, I believed that AA was a fairly prescriptive if not dictatorial organisation which aimed to encourage its members to adopt and adapt to its ideology (e.g. the need for abstinence) in a fairly rigid fashion. I now understand that same organisation prizes, absolutely, the individual experiencing of its members as being uniquely and inherently valid; no experience of an AA member is ever discounted. Members may cherry-pick that which they need to sustain their immediate recovery, but are encouraged to keep an open mind and not discard AA's teachings which are based solely on the phenomenological experiences of it members. It is probably AA's greatest strength, I feel, that people from varying backgrounds and with a diversity of experiences, can assemble in fellowship, united in the purpose of getting and staying well. It is this experiential base which gives AA's message of recovery its salience. This has particular clinical significance, I feel, as it means that AA can serve as a valuable adjunct to professional treatment and in no way poses any threat to the perceived hegemony of psychotherapy.

There has been much debate as to the rôle of the life-narrative. The ATRF has described it as an attempt to enforce conformity onto AA members; or the alignment of members to the broadly redemptive narrative of AA; and, in particular, the autobiographical exemplar of its co-founder, Bill Wilson (Rudy, 1986). But this study has indicated, I suggest, that the personal life-narrative is a crucial, if not primary coping-strategy in the daily life of recovery. It is a practical, self-convincing discourse which provides the rationale for an alcoholic to pursue his/her current lifestyle ("I do not drink and here is the reason why"). Clinically, therefore, I was taught by the participants that formulating this story (which does not have to make sense) is an essential tool in relapse prevention, as it helps locate a person within their personal recovery process. For this I am grateful.

Of recovery and relapse

I had believed that recovery for AA members was the binary construct of sober/relapse; I was wrong. Being a*n alcoholic-in-recovery* necessitates realising that, during the course of a natural day, an alcoholic is both in recovery and in relapse

simultaneously. In other words, there may be a fluidity (or ebb and flow) between being sober and moving towards that which might potentiate relapse, but this does not mean that each person will inevitably be doomed to relapse as the psychosocial world seems to imply.

Recovery is acknowledged as being fragile, because a person's mood, circumstance and environment changes, which produces corresponding negative and positive affect. It is these fluctuations which can cause the salience of alcohol to grow and subside. It is not the length of recovery achieved (notions of *recovery capital* are irrelevant here) but the fact that a recovering alcoholic knows that under no circumstance (whether happy or sad) can his/her life be made better by alcohol.

Not only is relapse perceived as a return to active-alcoholism, for those following an abstinence-based paradigm, it may involve a curious testing of self. The thought may occur:

"P2: ... I bet I could have a drink and never want another one again..." (P2: 191-192)

I now understand that this is not simply a matter of self-efficacy versus loss-of-control, but poses the basic question whether the consumption of alcohol, for an alcoholic, will trigger a process of wanting additional drinks after a single beverage is consumed. This process of wanting to consume further drinks is a phenomenon which has been experienced and which appears outside of their control. This may require further verification, but it seems to imply a phenomenological description of *craving* which is, temporally, located as taking effect *after* alcohol has been consumed and *not before*. Thoughts about drinking are termed by participants as "*obsession*" (P6: 196) which is unrelated to the ingestion of alcohol.

Clinically, I believe this suggests that relapse can be split into two elements; before consumption when cognition can be altered and so behaviours can be trained to be avoidant; and post-ingestion, where essentially a bio-medical process takes over which will remain unaffected by coping-strategies of self-efficacy.

<u>Of being alcoholic</u>

For clinical purposes I have had to diagnose patients as being alcoholic in conformance with DSM 5 and ICD 10 and the protocols of the hospital. However, the fact that the

participants referred to themselves as alcoholic does not mean that they do so in any diagnostic fashion (e.g. locating themselves on a continuum of severity), though the word *Anonymous* does hint darkly at the effects of stigma and experiences of vilification. Being alcoholic means that a person subscribes to the statement of Step 1 of the AA programme that the member was "*powerless over alcohol*" and that his/her life had been rendered "*unmanageable*" (AA, 1976: 59). These two metaphors, *powerless* and *unmanageable,* allow for any amount of differentiation between constructs of self which aim to describe what it means (and has meant) to the participants to apply these specific label to themselves. Consequently, I have realised that a clinical diagnosis may satisfy the inner workings of a treatment centre, but exploring the definition of *powerlessness* and *unmanageability* in the context of a client's self-construct and via his/her use of metaphor, may help match a congruent symbolisation of his/her experiences with how s/he phenomenologically experiences them.

An ethical dilemma

AA believes that "*once an alcoholic, always an alcoholic*" (AA, 1976:33) and the ethical position of my thesis (and that of the Ethics Committee) was to view the participants as being vulnerable adults (Liamputtong, 2007). I accept that this may be true on initial presentation for treatment, but there comes a point when this attitude must change. The participants had demonstrated by their lives and experience that alcoholism may be a chronic illness, but it is fallacious to construe alcoholism as a *relapsing* condition. After several years of sustained sobriety: exercising a high degree of self-awareness and reflexivity; reintegrating with their families; returning to employment; affiliating with AA; and providing examples of selfless altruism in helping fellow alcoholics, is it patronising, even discriminatory, to continue to regard these otherwise successfully functioning individuals as Rogers, (1961) outlined as being "vulnerable"?

I have learned that participants regard recovery as being "*fragile*" (P1: 496) and may even see themselves as being "*different*" (P6VT: 171) from others who consume alcohol, but I see no evidence from their narratives that they are unable to take care of themselves or are unable to protect themselves against significant harm or

exploitation. I feel that the ATRF is iatrogenically contributing to the stigmatising of a broad section of people (i.e. *recovering* alcoholics) who are functioning well as competent citizens. As with cancer, once in remission a person may be liable to recidivism, but the difference remains that the now recovering-alcoholic can take positive steps to reduce the potential for relapse. If this thesis achieves anything, it may be that it will help reduce the stigma brought about by the charge of vulnerability which, for those in sustained recovery, is ethically unwarranted.

Of me

I have been affected by this study which has absorbed over four years of my life, but it is perhaps too early, I feel, to define in every respect its impact upon me. I stand in awe of the courage of the participants (and AA members like them) and what they have achieved. It has emboldened me to hope that recovery is within the grasp of any alcoholic and that the illness of alcoholism is wrongly condemned as being a relapsing one. In that sense I am at variance with my ATRF colleagues.

I take to heart the comment made by P1 when describing his relapse, which was variously echoed by the remaining participants:

"... it's a difficult one, it's a difficult one to grasp unless you've been there..." (P1: 616)

There is a sense, therefore, in which one thing remains unchanged; I am still the critical observer of a phenomenon and no matter how close I felt towards the participants and how much they felt that I was trying to see the world through their eyes or from their frame-of-reference, I remained outside their world looking in. That was their message to me and that is also how I feel; I am not saddened by that because that is the nature of "as if". But that, in a sense, is how I discern that they even see themselves. Each looks from the coign of vantage of a Dr Jekyll at his/her own Mr(s) Hyde and wonders how the one became the other. I have gained, I hope, an appreciation of what AA affiliates mean when they describe alcoholism as "*cunning, baffling and powerful*" (AA, 1976: 58-59).

But, paradoxically and this perhaps exemplifies that particular quote from AA, on reflection, I feel a close affinity with the participants who describe characteristics or

personality traits which they attribute to their acquisition of alcoholism and which I readily acknowledge as being present in me, so that I might say, “There but for the grace of God, go I.”

But I have also been conditioned, as AA demands, by the need for participant anonymity. For, a brief few weeks/months as researcher and participant we moved within the same orbit and with a degree of intensity but then, sadly I feel, with the constraints of anonymity we parted; contact was broken; as AA states, “*anonymity is the spiritual foundation of all our traditions*” (AA, 1952: 13). The purpose of our encounter was professional, time bound and not therapeutic; contact with the participants began and ended with this project. But there remains for me an empty feeling, I miss this group of people and hope that I have sufficiently honoured the trust they placed in me.

This respect which I hold for the participants contrasted with the frustration I felt during the process of my literature search and critical appraisal towards the research arm of the ATRF. McLeod (2011) makes the point that there are two kinds of research within psychotherapy; the academic (which deals with concepts and ideas) and the clinical (which is eminently practical). The discipline needs both but there comes a point, I feel, when the world of concepts has to translate into clinical practice. It is intolerable that there are 25 different permutations used to define *relapse* (Maisto et al., 2016) and that the ATRF cannot define, consensually, the terms of *alcoholism* or *recovery*.

With all the solipsism of a dilettante the ATRF obfuscates and indulges in tergiversation whilst in the meantime, as P4 noted, “*Relapse kills; drinking kills*” (P4: 446). I found my literature search frustrating as it revealed to me an hegemonic world where academics were more intent in protecting their self-interest than finding a consensual way forward in treating a terminal illness. Why should the outcome of treatment be different for alcoholism when compared with other addictions? Why should cessation apply to nicotine and non-prescription drugs but not alcohol? Why are people held to blame for alcohol relapse but not with diabetes? Why hold such a fatalistic view of alcoholism?

But I was also angered that the current definition of alcoholism, based on the study of people seeking treatment or in the earliest stages of recovery, holds that it's most accurate description should be that of a "chronic relapsing illness". In the stroke of a pen it condemns a person to follow an interminable and hopeless cycle of recovery and despair with a futility which removes all vestiges of hope for the future; that is cruel.

And here I return to the vexed question of my rôle within the research process. A combination of frustration and anger had crept into my writing which I discerned *post-viva* and, whereas I championed the primacy of a participant's frame-of-reference (page 35), I also stated that I was *not* here to champion any social causes (page 146). But here, perhaps, I corrupted the definition of co-construction as I now realise that I have actively sought to facilitate the process by which the voices of the participants have been heard. In other words, I have deliberately tried to move into the wings, so that they could take centre stage.

More detailed reflections on the study will emerge as I write papers in the following months. At this stage, I must acknowledge that I was saddened and unprepared for the death of one participant and the serious illness of another, which prevented their validating their analysed data. My thesis is the poorer for their absence. But I was struck by the depth and the seriousness by which both had engaged with the process (as with all the participants) and their evangelical desire to broaden an understanding of alcoholism. They both exemplified the dedication which recovering-alcoholics show pursuant to a life of sobriety. I have learned an important lesson in life; a person can step back from the abyss and return to the sunlit uplands whilst there is hope. As P1 said of his move to recovery:

"*.... I know I had from that day forward, I had some hope*..." (P1: 443)

and with hope, the human spirit is never quelled.