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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Volume Two

(References & Appendices)

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Websites Accessed

Chapter 3: Literature Search

Step Nine Grey Literature

1) The BACP website Dissertation Database was searched (11/10/2014). There was one article on addiction linked to attachment theory but nothing was found relevant: https://www.bacp.co.uk/
2) The WHO website Management of substance abuse and linked websites (http://www.who.int/substance_abuse/en/) accessed 30.11.14
3) NICE Guidelines on alcohol use disorders (http://www.nice.org.uk/guidance/cg115) and
4) NICE guidelines on clinical management of drug misuse and dependence (http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf) accessed 31.11.14
5) British Association for Pharmacology Guidelines, 2012 (http://www.bap.org.uk/pdfs/BAPaddictionEBG_2012.pdf) accessed 31.11.14
6) Government Policy on reducing drug misuse and dependence (https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence) The Government's Alcohol Strategy (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf) accessed 31.11.14

Chapter 8: Participant Recruitment

AA Websites for recruitment purposes all accessed on 13/3/15

Northwest Intergroup, 47 meetings (http://www.alcoholics-anonymous.org.uk/members/Regional-&-Local-Websites/North-West-Region/North-West-Intergroup/Meetings)

Merseyside and South Lancashire Intergroup, 37 meetings (http://www.alcoholics-anonymous.org.uk/members/Regional-&-Local-Websites/North-West-Region/Merseyside-&-South-West-Lancs-Intergroup/Meetings)

Cumbria Intergroup, 24 meetings (http://www.alcoholics-anonymous.org.uk/members/Regional-&-Local-Websites/North-West-Region/Cumbria-Intergroup/Meetings)

East Lancashire Intergroup, 44 meetings (http://www.alcoholics-anonymous.org.uk/members/Regional-&-Local-Websites/North-West-Region/East-Lancs-Intergroup/Meetings

Appendix 1:

11th March 2015

Joy Duxbury/Howard James Marsden-Hughes
School of Health
University of Central Lancashire

Dear Joy/Howard,

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 294

The STEMH ethics committee has granted approval of your proposal application 'How do recovering alcoholics, attending Alcoholics Anonymous (AA), view the phenomenon of relapse?'. Approval is granted up to the end of project date* or for 5 years from the date of this letter, whichever is the longer. It is your responsibility to ensure that:

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Additionally, STEMH Ethics Committee has listed the following recommendation(s) which it would prefer to be addressed. Please note, however, that the above decision will not be affected should you decide not to address any of these recommendation(s).

Should you decide to make any of these recommended amendments, please forward the amended documentation to roffice@uclan.ac.uk for its records and indicate, by completing the attached grid, which recommendations you have adopted. Please do not resubmit any documentation which you have **not** amended.

Yours sincerely,

Ambreen Chohan
Deputy Vice Chair
STEMH Ethics Committee

Appendix 2:

Participant Information Sheet

Project Title: ***"How do recovering alcoholics, attending Alcoholics Anonymous (AA), view the phenomenon of relapse?"***

Date XX/XX/XXXX

Dear_____

You are being invited to take part in a research study, which forms the basis for my PhD studies in the School of Health at the University of Central Lancashire (UCLAN). Before making any decision, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with others if you wish. Feel free to ask me if there is anything that is not clear, or if you would like more information. Please take your time to decide whether or not you wish to take part.

What is the purpose of the study?

Research into the process of relapse has tended to centre on people seeking in-patient treatment in professional rehabilitation centres. Yet it is recognised that the vast majority of people (up to 80%) who experience alcohol dependence resolve their problems by other means; this includes membership of Alcoholics Anonymous. My research project starts from the idea that it is important to understand the lived-experiences of men and women who are members of AA, who have experienced relapse and who have returned to sustained-recovery through their membership of AA and following a Twelve Step Programme.

This research forms the basis of my PhD dissertation and is not part of any other study being carried out by UCLAN. It has been reviewed and approved by The Ethics Committee for Science, Technology, Engineering, Medicine and Health (STEMH) at The University of Central Lancashire (UCLAN) where I am a PhD student in Counselling/Psychotherapy.

The full study runs from now until July 2019, but your specific involvement is detailed below.

Who would we like to take part?

The study is looking for 8-12 participants who are 18+ years old. Participants can be men or women of any religious, non-religious, ethnic, social, educational or socio-economic background who view themselves as being in recovery from alcohol addiction.

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

1) You are in recovery from alcoholism with alcohol as your sole substance 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 and follow the 12-Step Programme as laid out by Alcoholics Anonymous
4) Alcoholics Anonymous 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 currently have an AA sponsor
6) You have relapsed at some point in your recovery or in your attempts to secure recovery (this may be one occasion or several times)
7) You would describe yourself as now being in sustained recovery for a period of 1-5 years
8) You have been sober for a period of at least two years since your last relapse
9) You may have received a medically supervised detoxification, but have achieved your sobriety through membership of AA alone and not required any other professional clinical/therapeutic intervention
10) You confirm that you are physically, emotionally and psychologically strong enough to re-engage with reflecting on the relapse process

You will not be eligible to join if you fulfil any of the following:

1) Persons for whom alcohol has not been their primary or sole substance of choice
2) Persons who are in active addiction for alcohol or other drugs or addictive behaviours (e.g. gambling)
3) Persons who are under 18 years of age
4) Persons who have relapsed within the last 12 months
5) Persons who are taking any medication prescribed by a GP, or other healthcare professional, the immediate purpose of which is to sustain recovery (e.g. Antabuse or other alcohol-craving suppressants, e.g. Nalmefene)
6) Persons who are currently or have, at any time, been diagnosed (or sought treatment through a medical practitioner or therapist) with any mental illness other than alcoholism (e.g. anxiety, depression, bipolar disorder, PTSD, etc.,)
7) You feel unable to confirm that you are strong enough, emotionally, physically or psychologically, to engage with reflecting on the relapse process

Participants will be selected on a first come first served basis. Due to the nature of this study it is not possible to accommodate large numbers of participants.

Do I have to take part?

No, it is up to you to decide whether or not to take part and if, after reading this information, speaking with friends, or your sponsor and thinking about it, you are in any doubts, you are encouraged not to do so. If you do decide to take part and are selected, you will be given this information sheet to keep and will be asked to sign a consent form.

Will I retain my anonymity?

Sensitive Personal data and other study data

There are three types of data which relate to this study; study data, sensitive personal data and sensitive personal data for comparison. Study data means the content of your interview, the transcript which is created from it and the interpretation of your words made by me. This study data will be anonymised, which means that any reference in the transcript or my interpretation which could potentially identify you in any way will be removed. When you check the transcript and my interpretation you will be able to satisfy yourself that there is nothing in the study data which could show that this study relates to you; this can be confirmed/amended by you at the follow-up meeting.

The second type of data is called sensitive personal data. This means data such as your name, address and telephone number. During the course of this study, this data will be known only by me and will be destroyed by me once the follow-up meeting has been completed.

The third type of data that is being requested is sensitive personal data for comparison. This relates to your gender, age, ethnicity and length of sobriety. It is hoped that, in time, this study will be read by other professional researchers and people interested in the study of alcoholism and relapse. To enable a comparison to be made between this study and others, it would be helpful if these four pieces of sensitive personal data could be used, however, you may choose not to have this sensitive personal data mentioned in the study.

At all times in this study all the forms of data used which relate to you, or can identify you, will be either anonymised or removed and will not appear in any transcript or written documentation. Any type of data which may indicate, imply, or infer who you are will be eliminated from all written material.

What will happen to me if I take part?

Your contribution to this study comes in two stages:

Stage One

First, you are asked to share with me, for approximately one hour your views and feelings from your own lived-experience of relapse. It will be similar to a main share at an AA meeting but longer. This session will be recorded on a hand-held digital voice recorder which I will bring with me.

The interview will be semi-structured (see below) to allow room for you to explain what you feel is important and significant to you about relapse. You may stop the interview at any time, without giving a reason and withdraw from the study. In this case, the recording will be wiped off the recording machine in front of you. You may also choose not to answer any particular question I put to you during the course of the interview, without stating a reason.

Initially there will be six general suggested prompt questions around the topic the study aims to cover:

1) When did you first experience relapse and what was it like?
2) How did you make sense of the relapse experience itself (including what factors caused it)?
3) How have your thoughts and feelings around relapse changed as a result?
4) Could you describe the most important lessons you have learned through experiencing relapse?
5) Has your experience of relapse affected the way(s) you manage your recovery?
6) Is there anything that you might not have thought about before that occurred to you during this interview?

Stage Two

Following the interview I will make an anonymised, word for word, typed transcript of the interview (i.e. any details which link you to the transcript will be removed). The interview and making of a transcript is called ***data collection***. I will then analyse what you have said and write a commentary on it trying to interpret and capture the essence of what you have said as accurately as possible. The transcript and interpretation will be anonymised and any events described by you, which could identify you in anyway will not be included and the transcript and interpretation will not include any sensitive personal data relating to you. This will take approximately 4-6 weeks. I will then arrange to hand deliver a hard copy of the transcript together with my anonymised interpretation to you, either to your home, or to a convenient location and at a time of your choosing. You will then be invited to read and consider both these documents and to satisfy yourself that the comments I have made are a valid interpretation of what you said. You may, or may not, choose to make any notes on these hard copies and that is entirely your decision. After a period of two weeks we will then arrange to meet again at a mutually convenient time and place and you will tell (or show) me any corrections you have made to any of my comments to ensure that you are happy that they are a true and accurate reflection of what you have said and that you feel assured that you cannot be identified in any way from the written material. This process will again take about one hour. This transcript, my comments and any amendments you have made will be used in the research dissertation.

If you feel at this stage that my interpretation has not captured the essence of what you have said, or that the interpretation identifies you in any way, you may choose to withdraw from the study at this time. You may also withdraw from this second meeting at any time, without giving a reason and for your data to be withdrawn from the study.

Both meetings will take place in the privacy of your own home, or at a location which we will mutually agree will be suitable to maintain confidentiality and privacy. We will meet on a date that is convenient to you.

Why is there a need for two meetings and what happens if I cannot, or choose not, to meet with you again?

The purpose of the second meeting is to validate and authenticate the information which you previously provided in your earlier interview and to ensure that you are satisfied that there is no sensitive personal data included in the transcript or interpretation. This shows that, as a participant in this particular study, you agree and are satisfied that I have not misrepresented you or altered the words from your transcript in anyway and that it is sufficiently anonymised. It also shows that you are in agreement and satisfied with my interpretation of what you have told me.

If for any reason you are unable to meet again, or you wish not to, I will ask your permission if your data could still be used in the study but without your validation and it will be clearly stated in the study that this data has not been validated by you as a participant. If you feel that you do not wish to give your permission for this to happen, then your participation in the study will cease at this point.

What happens if I want to withdraw from the study?

Initially, this study requires a period of data collection (interviews) from different participants drawn from AA members, followed by typing these interviews into word-for-word transcripts which will then be interpreted by me. At the second meeting with you, you will have the opportunity to agree and validate the work done so far, or to suggest amendments which will be included in the interpretation, or to disagree with the interpretation made in which case, your data will not be used. During all this process and *at any stage*, you are free to withdraw from the study without stating a reason and all your data will be removed from it.

After this stage there will be a further one month "cooling off" period from the date of our final meeting, during which you may still withdraw from the study if you choose and all your data will be removed from it. Again you do not have to state a reason. After this month's "cooling off" period it will not be possible to withdraw from the study and your data will be included in the final dissertation.

Once you have given your approval of the transcript and my interpretation the electronic recording of your interview session will be destroyed.

Will my taking part in this study be kept confidential and what happens to the results of the study after completion?

All information which is collected from you during the course of the research will be kept strictly confidential. All notes written by me will be stored on the UCLAN computer in an encrypted password-protected account to which only I will have access; these will be anonymised, so that no sensitive personal data of any type is revealed. Until the PhD is completed, transcripts, recordings and all notes will be kept in a locked filing cabinet to which only I will have the key.

It must be stressed that this study is part of a PhD research project at UCLAN. As such, it will be discussed with my supervisors and will lead to the study being printed and submitted to an examining body of the University by July 2019. It may also be published and appear in part, or whole, in periodicals and professional journals as well as being delivered to professional conferences. You are free to ask for a copy of the study when completed.

What is shared with me in our two sessions will remain confidential, understanding the points that were made in the previous paragraph, regarding the publication of the study to other interested, professional parties. This will not affect your anonymity or the disclosure of any sensitive, personal or other data (see above).

I work at all time to the ethical framework of the British Association of Counsellors and Psychotherapists (BACP) of which I am a member.

What do I have to do?

There is nothing that you are required to do in order to take part in this study except, when you are ready and feel fully satisfied as to the nature and purpose of the study, to give your informed consent. A suitable date and location will then be agreed for the initial interview.

What are the benefits for me in taking part?

There are no direct personal benefits for you. The aim of this study is to improve the awareness of perceptions and experiences of relapse by members of Alcoholics Anonymous, which may help to reduce the stigma attached to the condition of alcoholism and ultimately be of benefit to alcoholics in both active addiction and recovery

What are the possible disadvantages or risks in taking part?

In revisiting experiences of relapse, it is possible that strong emotions and feelings may be re-awakened, should that happen, you may access therapeutic support from Mrs. J. De-Maine, MBACP (Accred.), FDAP (Accred.).

What happens afterwards?

The research findings will be submitted to UCLAN; it is anticipated that this will take place in 2019.

All data (electronic and paper) will be securely stored for a period of 5 years from the end of the study and will then be destroyed. The recording of your session will have been previously destroyed.

What if something goes wrong?

As a practising psychotherapist I work within the BACP Ethical Framework of practice, which includes a complaints procedure. This research is being carried out under the governance of the University Of Central Lancashire (UCLAN), which also has a complaints procedure. In the first instance, complaints can be made by telephone, email or in writing to my principle supervisor;

Prof. Joy Duxbury
School of Health
Brook Building
University of Central Lancashire
Preston
PR1 2HE
Tel: 01772 895110

Secondly, contact can be made directly with the University Officer for Ethics who can be reached by email at OfficerForEthics@uclan.ac.uk quoting the title of this research which is at the head of this letter.

Copies of the guidelines from the BACP and UCLAN will be provided to you on request.

How long do I have to make up my mind whether I want to take part?

Once you have reviewed this letter and the consent form it is hoped that you will be able to make up your mind within two weeks to decide whether you wish to take part. If you are unsure or have any doubts at this stage it is recommended that you do not take part in the study, or contact me for further information.

If there is any point on which you require clarification then please contact me first, before signing the consent form.

This research is being self-funded by me and I gain no financial benefit from it.

Thank you for your time taken to read this letter and considering taking part.

Yours sincerely,

Howard Marsden-Hughes
c/o The Priory Hospital, Rosemary Lane, Bartle, Preston, Lancashire, PR4 0HB Tel: 01253 391145
Email: howardmarsdenhughes@btinternet.com

Appendix 3:

Informed Consent Form

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

Howard Marsden-Hughes,

PhD Research Student, c/o Priory Hospital, Rosemary Lane, Bartle, Preston, Lancashire, PR4 0HB

(Please read the following statements and initial each paragraph to indicate your agreement)

No		Initial
1	I confirm that I have read and understand the information sheet dated ___/___/_____ for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	
2	I confirm that I match the criteria for participation	
3	I agree to take part in the above study and for the initial session to be recorded	
4	I agree that the recording will be written up, word for word, in what is called a transcript	
5	I understand that you will interpret the data in the transcript and present your interpretation in a written document	
6	I understand that I will be given two weeks to read the transcript and its interpretation and I will be able to make comments and amendments as I feel appropriate	
7	I agree to meet for a second time to discuss my transcript from the initial meeting and to agree any interpretations generated	
8	I agree for this session to be recorded and transcribed if necessary	
9	I understand that you are asking for my permission to use my anonymised personal data within your final dissertation and any publications, or presentations generated from the study. This personal data will be restricted to include my age, gender, length of sobriety and ethnicity	
10	I understand that if I am unable, or choose not, to meet with you for a second time, you may ask my permission to use my transcript and your interpretation but without my validation of them. I understand that I may choose to refuse this request and that my data will not be included in the study and my participation in it will cease	
11	I understand that my participation is voluntary and that I may withdraw from the study and request that my data be removed without giving any reason for up to one month after I have validated and approved the transcript and your interpretation of my data; after this point I agree that my data will be included in the study and may be used for future research and for anonymised quotes to be used in publications	

_____	___/____/_15___	_____
Initials of Participant	Date	Signature
_____	___/____/_15___	_____
Name of Researcher	Date	Signature

Copy for Participant and Researcher

Appendix 4:

Semi-structured Interview Questions

Howard Marsden-Hughes

Title of Study: ***"How do recovering alcoholics, attending Alcoholics Anonymous (AA), view the phenomenon of relapse?"***

Six over-arching prompt questions will be used to illicit the participant's understanding of the phenomenon of relapse:

1) When did you first experience relapse and what was it like?
2) How did you make sense of the relapse experience itself (including what factors caused it)?
3) How have your thoughts and feelings around relapse changed as a result?
4) Could you describe the most important lessons you have learned through experiencing relapse?
5) Has your experience of relapse affected the way(s) you manage your recovery?
6) Is there anything that you might not have thought about before that occurred to you during this interview?

Other questions will appear which will emerge from the participant's narrative.

Appendix 5:

RESEARCHER RISK ASSESSMENT FORM

Risk Assessment For	Assessment Undertaken By	Assessment Reviewed
Service / School: Health	**Name: Howard Marsden-Hughes**	**Name:**
Location of Activity: Participant's Home	**Date: 12/12/2014**	**Date:**
Activity: Interviewing study participants Date of activity: Not yet known **REF:**	**Signed by Dean of School, Head of Service or nominee:** **Date**	

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
Verbal abuse and verbal threats, aggression	Self	2 people to attend visit (accompaniment by a friend)	Location of self in relationship to exits in the room	M
Physical assault	Self	Phone call before entering property giving time of entry and expected exit time. Phone call on exit		M
Verbal threats of violence	Self	Carrying a mobile phone		M
Racial/sexual harassment	Self	Carrying a personal alarm	Priory Hospital Training in conflict resolution and breakaway from physical assault	M

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
Emotional Trauma	Self	Personal therapy has been arranged with Priory colleague		L
Physical attack by pet	Self	Will not enter the house until pet safely placed in a room where the interview will not take place		M
Working after normal hours	Self	Time off in lieu		L
Working with people who are under the influence of drugs/alcohol	Self	Will not enter the house if the person is intoxicated or appears to be under the influence of drugs		M
		Breakaway training from physical assault completed training within Priory Hospital		M
		Training for Conflict Resolution completed within Priory Hospital		M

Appendix 6:

Validation Consent Form

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

Researcher: Howard Marsden-Hughes (G20389184)

School of Health

Date: x/x/xxxx

Participant X

Gender:

Age:

Length of Sobriety:

Ethnicity:

I confirm that I am satisfied that the transcript produced from my interview is properly anonymised.

I confirm that I have also been interviewed and recorded signifying my approval that the researcher's interpretation was an accurate reflection of my thoughts surrounding relapse and that I have not been misrepresented in any way.

Participant
Signature:_____

Appendix 7: Extract showing method of literature review

This appendix provides examples of the initial data analysis of 77 papers which comprised my literature review. In trying to understand the phenomenon of relapse I selected papers which appeared sympathetic to this cause and whose titles, therefore, included the words: *narratives; stories; accounts; (lived)-experience(s); abstinence; AA; autobioggraphy; meaning; recovery; process; pathways; views; voice(s); phenomenological;, follow-up; insider; vignette;, or client's perspective*. As such, these papers were understood to be seeking to comprehend the phenomenon, qualitatively, from the experiences of their participants. Following the writing of Boote and Beile, (2005), to provide a means of analysing the papers in a systematic fashion, attention was paid to the following:

***** 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

This initial six-point approach was applied to all the papers. The papers are reviewed alphabetically and were later grouped by methodology for a more detailed critical review of their findings.

1. **Ball, C. T. and Little, J. C., (2006) A comparison of involuntary autobiographical memory retrievals, *Applied Cognitive Psychology*, 20 (9): 1167-1179 (Academic Research Complete)**

   Aim: To compare the ways in which autobiographical memories are elicited involuntarily.

   Participants: *n*= 228 (mix not specified)

   Methodology: Comparative analysis

   Ethical Approval: N/A

   Origin: USA

Findings: This paper was a theoretical discussion of the nature of memory and the rôle of involuntary autobiographical memory and was not relevant.

2. **Best, D. W., Gow, J., Know, T., Taylor, A., Groshkova, T. and White, W., (2012) Mapping the recovery stories of drinkers and drug users in Glasgow: Quality of life and its associations with measures of recovery capital, *Drug and Alcohol Review*, 31 (3): 334-341 (Academic Search Complete)**

   Aim: To investigate what recovery means for those describing themselves as being in drug or alcohol recovery and to identify what recovery factors and aspects of living and functioning were most associated with quality of life.

   Participants: *n= 205* (107 in alcohol and 98 in heroin recovery); mean age 42 years; 66.8% male; 51.7% single; 71.7% in recovery for 1-5 years; 40.5% had been incarcerated

   NB The alcohol group were older (48.9 years); included more women; lived with partners; had experienced employment and less homelessness and prison. They had experienced a longer time dependent (15.7 years); started drinking later in life (24.8 years); had continued drinking for longer (16 years); had more detox attempts (3); and started in recovery older at 40.9 years.

   Methodology: Cohort study using semi-structured questionnaires and interviewing; opportunistic sampling

   Ethical Approval: Yes

   Origin: UK

   Definitions: “in recovery” had not used the primary substance for 12 months, but could be on a substitution treatment programme; “abstinent” had used no opiates in the last month versus “maintained” i.e. had received opioid substitution in the past month.

   Findings: There are three common elements for recovery: Well-being, sobriety and citizenship. Early recovery lasts from 0-3 years, sustained between 3-5 years and stable 5+years. Yet recovery is an on-going journey and a personal s recovery or what it looks like is unknown. Symptom reduction is important but may only be one factor. It is linked to the need for social networks and quality of life. Abstinent alcoholics reported greater quality of life. Their social network had fewer drinkers. They engaged with more pro-social activities and peers who were in peer-based recovery. The paper hypothesises that personal and social recovery capital are mutually generative, where engaging with peers in recovery is part of a community engagement. Together with meaningful activities this builds a positive identity and protects against relapse.

3. **Bond, L. M. and Csordas, T. J., (2014) The Paradox of Powerlessness, *Alcoholism Treatment Quarterly* 32 (2-3): 141-156 (Taylor and Francis)**

   Aim: To understand how women make sense of contradictions within a male-dominated and male-centred AA programme.

   Participants: *n= 10* all female; 3 years sober; mean age 51

   Methodology: Qualitative Cohort Study: Interviews

   Ethical Approval: N/A

   Origin: USA

   Findings: Whilst feminist literature views powerlessness within AA as a further example of androcentricty, the 10 women in this study saw their admission of powerlessness as *agency* and not as being equivalent to powerlessness in other areas of their lives. They accommodated this to their own healing as a paradoxical gaining of power (i.e. letting go of the illusion of control or kenosis). Going through the steps helped them regain power (empowerment) and make new choices and responsibility by gaining self-knowledge (knowledge is power). This led to self-acceptance and knowing what the person wants; it removes docility. Women can intervene and create a world of recovery which was not, perhaps, fully designed for them. The study also recognised the notion of *surrender to win*, as part of increased agency, taking responsibility and gaining control. Surrender was getting rid of a burden. Nor did they have to assume the view of God (in Step 3) as being equal to maleness. Their view of the first three steps was contemplative self-effacement, versus self-destruction and self-repression which came from addiction.

4. **Bone, R., Dell, C., Koskie, M., Kushniruk, M. and Shorting, C., (2011) The lived experience of volatile substance misuse: How support contributes to recovery and sustained well-being, *Substance use and Misuse*, 46 (S1): 119-127 (Academic Research Complete)**

   Aim: To examine the role of support and sustained well-being in the life of two recovering native Canadian volatile substance abusers.

   Participants: *n*= 2 (One male one female First Nation Canadians) aged 50's; in recovery for 10 years

   Methodology: Visual arts and oral life history methodologies

   Ethical Approval: N/A

   Origin: Canada

Findings: The use of volatile substances indicates an imbalance in a person's life and serves as a coping mechanism for stress. In the ATRF, knowledge of personal recovery is negligible and unexplored. Support is both structural (e.g. social integration) and functional (e.g. social networks) and helps with relapse-prevention and the recovery process. Western models of addiction treatment are only now beginning to address the role of emotional, spiritual and mental well-being within recovery, historically viewing people as unique, separate and autonomous, rather than relational and interdependent. The psychological components of support are: *social embeddedness* or a sense of community; *perceived support*, that it will be available when needed, which improves well-being; *enacted support*, the actions of others when support is needed in the face of stress (Barrera, 1986). Support is reciprocal; if not or only partially experienced, it cannot be offered back, hence a person can become isolated. Recovery within mutual-support groups helps forge connections, finding links, similarities and patterns within this culture, creating a sense of interdependence not found elsewhere within society. This also needs to be integrated into a person's cultural background.

5. **Brewer, K. M., (2006) The contextual factors that foster and hinder the process of recovery for Alcohol Dependent Women, *Journal of Addictions Nursing*, 17 (3): 175-180 (CINAHL Complete)**

Aim: To understand the lived-experience of women in abstinence-based recovery from alcoholism.

Participants: *n=11* women, aged 32-76 years old; self-labelled as alcoholic; in recovery from 2-37 years; abstinent for 2 years; snowball sampling; ability to write and read English

Methodology: Phenomenology: 45 minutes taped interviews; constant comparative method

Ethical Approval: Yes

Origin: USA

Findings: Little is known about the aetiology of alcoholism, or the contextual experiences of recovery and most studies focus on alcoholic males (generalised to women). Addiction is stigmatised and has negative moral overtones, especially for women. Recovery is abstinence and adapting to a non-drinking lifestyle. Current understanding emerges from clinical observance of male practitioners; folk wisdom and quantitative studies of people who have experienced spontaneous remission (Kinney; 1996; Suissa, 2003). Recovery means evolution and personal growth and is life-long. AA is the gold standard of recovery and relapse is expected (Larimer, Palmer and Marlatt, 1999),

certainly within the first two years of recovery. Factors that enhance recovery are, working a programme within a mutual-help group; developing a support system; making amends/reparation for the past; helping others who are struggling in recovery. Factors which hindered the same are: everyday stress (developing coping mechanisms); feeling stigmatised; dealing with painful childhood memories (9 of the 11 experienced sexual abuses in childhood). All participants believed that women alcoholics were stigmatised.

Appendix 8:

Additional confounding variables within the ATRF (affecting the acquisition of alcoholism and potentiating or predicting relapse)

(This section relates to Chapter 3: Literature Search, page 85)

A meta-analysis of the effectiveness of current addiction treatments was conducted by Castonguay and Beutler (2006). They reviewed different types of presenting addictions (i.e. behavioural and substance focused and including eating disorders) and the suitability of various mainstream therapeutic modalities in their treatment. Participant factors affecting addiction acquisition and treatment-outcomes (i.e. the potential for relapse) focused on a penumbra of confounding variables exhibited by addicts including: gender; age; ethnicity; psychiatric comorbidity (anxiety, depression and personality disorder and other psychiatric disorders), etc. Attention was also paid to variables which affected the clinician's ability to deliver treatment and the therapist/client relationship, though this is outside the remit of my study.

Within my literature search papers identified a smorgasbord of variables each considered, by the ATRF, as legitimate areas of research which could affect: the acquisition of alcoholism; the ability of a person to engage with treatment; and his/her ability to avoid relapse and so secure meaningful recovery. This list, which is far from exhaustive, includes:

- age (Hibbert and Best, 2011)
- gender, as the majority of studies predominantly involve white males (Cheney et al., 2009)
- frequency, duration and severity of alcohol ingestion (Billings and Moos, 1983)
- levels of craving (McIntosh and McKeganey, 2000)
- education (McIntosh and McKeganey, 2000
- age at onset of ingestion (Grant, 1998)
- family history of alcoholism (Grant, 1998)
- marital status (Schneider et al., 1995)
- employment status (Fiorentine and Hillhouse, 2003)
- personality (Miller, 1991)
- lifestyle (Castonguay and Beutler, 2006)
- peer pressure (Zywiak et al., 2003)
- stress, anxiety and negative affect (Higley et al., 2011; Pilowsky et al., 2013)

- legal and financial problems (McIntosh and McKeganey, 2000)
- comorbidity of other drug usage (Walton et al., 1995)
- effects of repeated withdrawal (Becker, 2008)
- outcome goals e.g. total (Donovan et al., 2012) or partial abstinence (Tiffany et al., 2012)
- membership of self-help groups including AA (Gorski, 1986; Vaillant, 2003)
- religious beliefs (Cheney et al., 2009; Kelly et al., 2006, 2011, 2012)
- behaviour change (Walter et al., 2006)
- development of spirituality (Kelly and Greene, 2014)
- age at first ingestion (Hibbert and Best, 2011)
- personal levels of motivation (Becker, 2008)
- self-identity (Heather, et al., 1975; Wasmuth et al., 2014)
- length of sobriety (usually measured in months) (Walton et al., 1995)
- AA commitment (Cheney et al., 2009)
- personal feelings of self-efficacy (Marlatt and Gordon, 1985) and coping (Walter et al., 2006)
- relapse severity (Castonguay and Beutler, 2006)
- social support (Piasecki, 2006)

What is not clear is how far such variables/stressors, singly or in aggregate, serve to affect an individual.

Appendix 9:

Example of expression of felt-sense (Gendlin, 1964) P2

The following was typed immediately after the interview and is unedited.

"Several words dominate my sense of this participant; determined; independent, shame, regret, passion, relationship. She was a casually, but neatly dressed lady, who welcomed me into her home and advised me on the doorstep that the dog had been put outside. She was clearly frail and despite the fact that she found her breathing difficult still smoked. She had obviously made an effort to look as "well" as she could. During the whole interview she sat side on to me and looked out of the window, never once looking in my direction, so that I only viewed her profile. Her head was tilted ever so slightly back, so that she looked over her nose at what lay before her. I witnessed that she became visibly tired during the course of the interview and the effort of looking "well" was beginning to tell. I felt quite protective of her and did not want to over tire her, but she appeared adamant that she was going to continue. I mentioned this before the interview but the suggestion was quickly dismissed with a rather imperious wave of her hand. As she described aspects of her relapse she was visibly moved, but still battled on to describe the effect.

I was struck throughout her narrative by two things. First, her awareness of the impact of her relapse (and her drinking) on her family especially her husband; this clearly worried her, though she was, at first, hesitant to admit this. Secondly, the lengths that she went to in order to protect herself against any possibility of any future relapse. She was an independent lady, but gregarious and liked nothing more than being around people. I sensed that she disliked being on her own.

Her independence was reflected in the fact that, despite her health, she continued to smoke; she was quick to refute any suggestion that she did what she was told by people in AA, but behind this bravado lay a sensitive woman. I noticed that she often used the word "we" to describe her day to day life which was centred around her husband. I found this touching and there was a tenderness as she mentioned him, as if to remind herself of the pain she had caused. I sensed she felt this keenly and regretted the worry she had caused and also the time that she had wasted (in many aspects of her life).

The effect of her drinking and relapse on her family was a subject about which she felt keenly but, in another way, did not wish to dwell upon, almost wanting to brush it under the carpet. When asked if she felt that her relapse had affected her family she was quick to say not, but then her voice dropped to a whisper as she recounted feelings of shame and the fear she had caused. She was on the one hand the dominant, independent, driven woman whose job it was to succeed, but now she was fighting a terminal illness and was dependent on others. This was a significant rôle reversal for her, but her recovery gave her an inner strength.

I sensed a deep bond between her and her husband and family. I also sensed that despite anything she had achieved, hers was a life of regret; time was now precious for her and in short supply and her addiction and the way she had been pursuing a career

was being viewed as having been a waste of time. Only now had she discovered what was, truly, important to her and that was being with a loving family; she had probably always known this, but had taken it for granted. So she had been able to prioritise her values. She dealt with the shame of her past by staying sober as a kind of penance. I felt that her relapse had resulted in a granite-like determination that she would never drink again.

She also needed to be clean of the past. I felt that her renewed Catholic faith gave her a peace of mind and that she could face the future, connected with her God and sensing His relationship with her. I am not sure if she was angry with herself, but she was capable of anger, especially when her father died; this was a woman who sought to control a situation and things outside her control had troubled her.

She had worked in a male-dominated company and had achieved a place at board level. Her work seemed to be important to her and had defined her as a person. She seemed proud of this fact and that she had her independence. But she had been gravely affected by the death of her father which had triggered feelings of anger against God (she belonged to a close knit Irish-Catholic-Liverpool family) and she had become a difficult person to be with. Despite the bravado, I sensed a little girl, who needed protection which she got in full measure from her husband. She had to be someone who was occupied and could accomplish things, but this was a far cry from the person she really was. Her work life was a façade.

There was now a sense of calm, contentment in her life; she revelled in the closeness of her family; she had her faith back, she practised her Catholicism, she had found a new meaning in life and she was protective of all that she had. She seemed to be accepting of her medical condition and she was accepting of the fact that she was going to die earlier than anticipated; she did not want above all to cause distress to her family. But she was ready for this next big hurdle; she was not out for the count.

She held firm views, but was at peace with herself. I had a sense in which she reserved her energy to engage in a battle where it was now needed and her priorities in life were focussed on her health and family. There seemed to be little chance that she would allow extraneous things to bother her. She was utterly passionate about AA and the following of the 12-Steps in particular and viewed its application to other forms of life threatening situations as helpful. As a guide to life, she believed it had helped her deal with her illness, even though she could see that others around her were struggling to cope; she had to be strong for her family. But she could only accept and come to terms with dying with the guidance of the 12-Steps and support of others.

Her husband in this way was her rock and she clung to him as well. But I sensed when she talked about being truly honest with another human being, that that person was not her husband. There seemed to be things in her past which were too troubling which she could not divulge to him and which would be too hurtful; he had suffered enough at her hands. Her one, major regret in life was the emotional pain and anguish she had caused to others.

She was puzzled by her relapse, there was no need for it nor did it benefit her in any way nor did she, effectively, attempt to provide an explanation for it. Her struggle to

explain relapse was couched in broadly similar terms to P1. Unlike him I did not feel that she needed to make sense of it with the same clarity as he did; there may have been many options of explanation, but she was happy with what she had decided. If P1 was the male reaction to stress and its causing relapse, for P2 the emphasis was on relationships (primarily with herself) which, if got right, removed the need for alcohol. The fact that her relapse had not followed a prototypical course (i.e. she did not go on to drink more) only added to the puzzle. She was a fun-loving person and it was delightful to hear her realise that she could have fun and live life without drink. She was squeezing out of life everything should could, living one-day-at-a-time, like recovery itself, was a precious gift for her. She even joked about her funeral.

Relapse, however, and the memory of what she had done haunted her. Three years later she could still be traumatised by the event, the fearful recall of which precipitated immediate and evident distress. As with life, I sensed she recognised the fragility of her recovery and was genuinely frightened by the way her mind could be subject to distorted thinking. She had been reckless during her drinking; her relapse demonstrated that the reckless side of her nature was still present and, even now, her strict way of being served to counterbalance that inherent volatility." (23/4/2016)

Appendix 10: Letter of Intent P2

Copy

Dear Howard,

When we had our first interview for your PhD research I mentioned to you that I had a medical condition which was quite serious. It is a real pleasure to be able to take part in something so worthwhile and I benefited greatly from being able to talk about relapse and what it means to me. In AA we learn the benefit of being able to talk openly and honestly about the past as it keeps us sober today.

This letter is to advise you that should anything happen to me and we are unable to go through your interpretation of our interview together, then I want you to know that I give you permission to use what we have talked about so far in your studies. You were a good sympathetic listener and I trust your judgement. So, hopefully all will be well and I look forward to seeing the transcript and going over it with you, but in case this is not possible please go ahead and use our interview with my blessing.

Kind regards,

Yours sincerely,

Appendix 11: Validation letter P4

15th December, 2016

Dear Howard,

I am very sorry that I am not be able to have our follow up meeting as I explained. I have signed the form and an am returning this to you. My anonymity was preserved in the document and I felt that you captured what I said very well, certainly better than I could have done!

As promised I have jotted down some other thoughts which came from your essay which I hope bring more clarity to what i (sic) said and what you wrote about me. They are not in any particular order.

My relapse was planned but was not deliberate. 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. I wasn't convinced I was alcoholic and so thought I could control it.

Humility only really began to emerge when I did step 4. A lot of the time I didn't understand about what people were talking about when they mentioned spirituality. Only when I began to explore my moral values did a change come over me. I thought I had only one defect of charater, (sic) but I discovered that masked many more. I stated looking at myself honestly and realised the extent of my ego, I was arrogant. I was quite ashamed of just how arrogant I'd been. Humility taught me that there was another way and that i (sic) was prepared to be taught by others. Going through the steps is an exercise in humility. At the start much of it you take on trust and it requires humility to stop thinking that you can do it on your own.

Gratitude is a selfless spiritual action. If you admit you are worng (sic) that takes humility, to help other people with the benefit of what you learn simply because you want to help them share that feeling is gratitude. If I can't show gratitude then it means I haven't got it in the first place. I was the given a gift of a second chance after my relapse and I hope I show how grateful I am for that.

Recovery is a journey and you get your sobriety by following thepathway (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.

Someone once said AA will love you when you can't love yourself and I believe that. It is like a family which does not expect too much of you. I almost lost my family and could do so again if I drink, but AA will never walk out on me no matter how bad I get.

Spirituality is about the changes I make in me but it is also practical. For me it is a collection of the values I was taught by parents, thevalues (sic) I have tried to teach my children and grand-children, what I learnt at school, in Church and in AA. But it is about putting this into practice. I believe in God, but I think he works through people, so spirituality also includes how I am with people and people in AA who I trust to help me. It is also about the way I behave. I want people to tell me if I am stepping out of line, because now I want to improve for me and for them. Spirituality is not all about God.

Sobriety is the life I lead now, to day. I'm not bothered about how I will be in 10 years time, it is today that matters. The quality of my recovery and what I do today will determine the quality of my sobriety. I only ever have one real goal which is to be sober, because if i am focused on that in the way AA tells me then I will behave and think well.

AA is my medication for getting well, but I can easily con myself that I don;t (sic) need it. That's arrogance, that's my old way of thinking, that's the drink talking. You talked about relapse being a return to drinking. I see it as a return to thinking and a way of thinking which will lead eventually to a drink. In a way I had taken that drink in my head before I picked up the bottle, I wanted to be like I was before and I was arrogant enough to think that I could control it all. AA gives me time to think and time to cool off and get another view and usually the other view is something that I haven't thought of and is much simpler.

During the course of a day you move in and out of relapse, and it doesn't mean that your always going to drink but you're thinking of drink but maybe what I am suggesting is that you are moving through different emotional states, contexts, different situations that may be more dangerous than others so in, as you put it, a kind of oscillation during the course of any one 24 hours but the aim is always to get to the end of that day sober, close off the day, put that to one side, start a new day.

I've got to remind myself of what it was like when I was drinking and what it is like now. The one is good the other is bloody awful and i always try and keep that balance with me. I see people who are going down the drain and I say to myself, that could be me if i didn't do what I do.

I described AA last time we met as road map for life, or a code of practice and I think if it is not taken too literally bearing in mind it was written 80 years ago and provided it's taken sensibly with advice, it will, give all alcoholics the alternative to live a full meaningful, happy, contended life.

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.

Every alcoholic experiences alcoholism in his own way, we are all different, but there is a common bond, I called it synergy. I may not have experienced something that someone is talking about, but I can understand what they are saying because I am an alcoholic, and I

know they will understand me, even if they have not experienced what I am talking about. If you're not an alcoholic you won't get that. We learn from others in AA because we can all do things and think in the same way. But what I do to keep sober may be different from someone else because I need to do what is right for me.

I hope this helps and I am sorry that we cannot meet again. It was a pleasure to meet you and for letting me take part. I wish you well for the future.

Yours,

Appendix 12: Extract from textual analysis (P1: 47-72)

(To demonstrate initial textual analysis notation)

47. ***R: So you stopped after 10 years, you had been 7 weeks sober, you've got to go back to work***
48. ***for a job inter…, for a return to work interview....***
49. *P1: Yeah.*
50. ***R: ...there's a lot going on in your life with your daughter....***
50a. *P1: Yeah.*
51. ***R: ...there are all these emotions that are going on...***
52. *P1. Hm.*
53. ***R: (pause) ...why did you go back to drinking? Why, why the relapse?***
54. *P1: It was to get rid of the fear and the feelings, to change the way I was thinking, um, I'd*
55. *completely, when after coming out of this interview, I completely lost faith, er, I'd lost*
56. *complete direction, had no direction of what to do next or what was next for me.*

There is an inconsistency here, perhaps. He does have some direction; he is going to buy alcohol. Drinking is now described as a means to get rid of fear and negative feelings, whereas he has previously described the cycle of drinking as being unstoppable to the point that he quit only because he was physically sick. There seems to be two conditions one emotional and the other physiological. He has not mentioned craving explicitly, as yet, but there seems to be several processes playing out simultaneously:

- first, a belief system that alcohol removes emotional and physical pain
- second, a physical need for alcohol where he drinks to the extent that he cannot drink anymore due to physical sickness
- third, as an escape from his current situation
- fourth, as a means of exerting control over a situation (though not necessarily over the act of consumption)
- fifth, another belief system that it is better to drink than to remain sober; choice versus self-control?
- sixth that sobriety, in this case, is not worth it as there has been no improvement in a life of sobriety over a life in recovery
- seventh, perhaps (as with his company in the past) he feels he can get away with it

- eight, whereas his family could have acted as a restraint to his behaviour, their rejection of him means that they provide no brake to his behaviour
- nine, stress from the emotional effect of his current situation (he senses a lack of empathy)
- ten, he drinks alone and in a non social setting (i.e. in a car in a car park)
- eleven, there is an immediacy of consumption
- and, finally, there seems to be no pre-planning

To date the description of his relapse has followed a fairly conventional pathway (as understood by the ATRF) and has been focused primarily on a process described in a linear, temporal pattern. Presented with emotional and life stressors and with inadequate and poorly formed coping-strategies, an alcoholic may often revert to type, especially where alcohol severity has been high (Babor, 1986; Emrick et al., 1993; Bruns and Hanna, 1995**;** Li et al., 2007). There is a mistrust of P1's own coping ability (Litman, 1986). Alcohol fills this void in the ability to cope by providing a brief respite from negative-affect, but will precipitate feelings of guilt and remorse. It follows a pattern of attributing failure to external factors, which may contribute to an artificial weighting of a multiplicity of relapse precipitants on interpersonal or non-personal factors (Donovan, 1996).

Perhaps P1 does not have the relative coping-skills and cannot, therefore, deploy them in a timely and appropriate way, or chooses not to (Edwards and Gross, 1976)? Nor does he have the social support from his family. Chapman (1996) posits that it is not just coping without alcohol but the re-establishing of meaningful social connections which can help attenuate relapse; these are absent here. The reaction of his family may play a rôle in the relapse process as well as P1's personalising of the responsibility and acceptance of guilt and shame. The lack of coping-resources is supported by Miller et al., (1996) as being responsible for 85% of all relapses. This provides a lack of protection against relapse (Connors et al., 1996).

Dealing with emotional pain is here linked to a desire to "*change the way I was thinking*". It seems as if alcohol allows P1 to reconceptualise his current position in terms of his family and occupational position but now, he significantly adds an existential bias. Is the change of thinking about the situation or about himself? Why

the need for change? What drives him into the arms of alcohol which has caused the problem in the first place? What is it that he is running away from? He does not seem to have anything in his life which, as yet, counterbalances the "*fear*" he experiences.

He experiences a psychological risk because he experiences a sense of loss; of identity (self-construct); of purpose; of direction; and a loss of hope. Relapse characterises an existential crisis point in his life. There is a very powerful theme of the "Lost Soul" which he uses metaphorically. There is confusion as to what he can possibly do next to rectify his current position in life. He is bereft, desperate and feels abandoned. This may be akin to AA's description of alcoholism as "*soul sickness*", but that is used to describe the process of active-addiction. P1 has tasted a freedom from active-addiction. He faces a bleak future, abandoned by those he loves and alone. Underneath all this I sense a feeling of profound shame. The shame comes in two forms: first where life has taken him and secondly the feeling of a loss of personal control over life; the one happens before drinking the other as a result of drinking. There is a shame borne out of personal failure: how he views himself; how others view him; loss of opportunity; of success ruined. He has reached an existential crisis point in his life which he never expected or planned for. What now is his existential purpose? There is another shame compounded by the fact that he has returned to a behaviour which is maladaptive. This shame is not sufficient to prevent consumption though.

I note (in this section) that he uses the words "*completely*" or "*complete*" five times. I am curious about this. This is the final relapse before a period of sustained sobriety. I wonder if in the telling of the tale P1 has to describe a hitting of rock bottom, a nadir of complete despair after which the process of salvation/re-building can begin. Does the rock bottom prove, in retrospect, the sincerity of P1 and his worthiness to be accepted by his family and society? Relapse can become the convincing final proof, provided that abstinence is, subsequently, maintained.

In understanding the re-telling of relapse does there have to be a break, or line in the sand, which marks the end of one period of life and the beginning of a new? The drinking part of life has to be "*completed*" before the new life can begin. There can be no carry over from the previous life into the new. An active-alcoholic's life has to come to an end and this marks the conclusion; there is no faith, no hope, no direction, no support but now into this vacuum will step AA. There was a period before, (7 weeks ago when he first stopped drinking) that he felt that a turning point in his life

had been reached, but what has now emerged is the realisation that this was not the rock bottom, as there was the current relapse still to come. As Lear says, "This is not the worst, if you can say "This is the worst"". There was the hope (false as it turned out) that the previous gaining of sobriety would bring with it positive changes which would have provided him with the motivation to staying sober (Prochaska and DiClemente, 1986). This did not happen; his expectation of improvement was dashed adding to a sense of failure. The lost soul after this relapse is ready for salvation and until the person becomes a lost soul salvation cannot begin. Is this what he is telling me?

The fear, loss of faith and direction also suggests the theme of control. P1 has lost control of himself, his environment and his influence on others. He cannot be an influence on his life or the lives of others. He is powerless to change the perceptions of others rendering him helpless. He exercises control by escaping from the situation he finds himself in. Only now can the process of healing begin.

56. Um, I
57. would say I was at a complete loss (pause) of not knowing what to do, where to turn and it
58. just ,er, a dreadful experience that all my life I'd planned, worked for, succeeded and I'd come
59. to this point and I couldn't just see any way forward other than the drink to take away the pain
60. and take away the fear, um, and just a human being without loss, without with loss and
61. without any direction is just a lost soul, a completely lost soul.

This presupposes that P1 has not yet discovered AA or that the mechanisms of AA have not begun to take effect. There is a paradox here in that the alcohol is claimed to take away the emotional/psychological pain, but provides physiological distress and a round of constant vomiting, so sick that he cannot drink. There seems to be something more going on here than numbing emotional pain. What he seems to be describing is not necessarily connected to alcohol. All that he hoped for, dreamed about, planned for, have disappeared. The existential turning point after striving and succeeding has resulted in him become a hopeless drunk. Perhaps this is why AA members call this *bankruptcy*. He is about to lose all trapping of status and meaning. Again I am struggling to decide between this as the description required of an alcoholic in AA, or whether this is an accurate description of how he was. Why has he externalised this to

become "*a human being*". He seems to be looking at himself from the vantage point of recovery and inviting me to look at him in the same way. He seems to be saying, "***This is the point from which my journey of recovery began. It is a figure of pity, a shell of a man, but now this can be contrasted with what you see before you***." One thing is for certain, this man who has been master of his own destiny, who has striven for what he wants and succeeded, has suddenly been stripped of all his success and now finds himself on the lowest spoke of fortune's wheel. There is something of a tragedy here, (cf Lear, Job, Oedipus), but is this all his fault? It is a moment of catharsis.

The first negative view of alcohol relapse

At this point, relapse may represent an existential crisis point in the life of P1. Whilst alcohol is sought and provides an immediate sense of emotional numbness, it is also accompanied shortly afterwards by intense feelings of guilt and remorse. This may be more than just going back on your word (the promise not to drink) or the feeling that a short period of recovery has been a waste of time. Relapse represents a nihilistic void where he is aware of his own inability to control his drinking and that, whereas in the past alcohol has provided some benison of ease and comfort, even that is now denied to him. In his angst, it appears that he is fated to live in the manner he does. There is no hope, no room for or chance of improvement. His life at this point is purposeless and, furthermore, he serves no purpose. He has failed as a husband, a father, and employee and as a human-being. The one substance that he has trusted as a means to function has also let him down; it no longer produces the effect that it once did. He has nowhere else to turn as, previously, he placed all his reliance on alcohol and this has betrayed him. He can see no way out of his predicament and cannot point to finger of blame at anyone or anything else. His situation is of his own making and he knows that. His own feelings of self-worth and value have dissipated. He is alone, despised by others, despising himself for what he has become and the effect of his life on the people he knows. He has contaminated everything he has been in contact with; he has the Medusa touch.

62. ***R: So, the drink doesn't, the relapse, the drinking again doesn't solve the situation, doesn't give you***

direction it just takes away...
P1: The pain.
R: ...the pain.
P1: Takes away the pain and then as soon as you, you wake up in the sobriety, the, er, you're not
as drunk as you were but I wouldn't say you're sober, er, the only way to get it, is then
that there is a craving for the alcohol as well, but to get back to a level playing field for me was,
to be in a drunken stupor again, and someti... when I think about it now, the, my perception of
my drinking was that I kept the drinking at a level, I never got to the point where I was falling
down drunk and it has been suggested that I might have been self-medicating to keep that
fear down.

We are now looking at his drinking pattern from the vantage of recovery. The level playing field is an interesting metaphor which seems to suggest an ability to function in some way that precludes "*falling down drunk*" but, at the same time, provides a means by which an individual is "*self medicating*". It is part of the process of comparison, i.e. "I was never that bad because compared with..." Themes here are functioning and self-medicating, but above all, CONTROL. The notion of self-medicating is not mentioned in *The Big Book* of AA (AA, 1976), so this is an idea which seems to have emerged, for him, independent of AA's teaching.

Khantzian and Albanese (2008) argue this point. Addiction, they suggest, is a problem of self-regulation and where affective distress prompts an individual to choose specific drugs. The use of drugs is to alleviate pain rather than to seek out pleasure. Alcohol acts as an emotional anaesthetic, but at what point does it take on this rôle? I think P1 is becoming confused in his narrative. Is he suggesting sobriety allows for drinking? This would be contrary to AA teaching. What precisely is he trying to describe? What is the level of adequate social-functioning which can be maintained before relapse occurs, or he appears intoxicated? This must be a difficult position to maintain requiring some effort, planning and conscious control and yet, he seems to have been successful at it if his company were not able to challenge him, directly, about his drinking and its effects on his work. To be able to drink at a level that satisfies his need for alcohol (occasionally getting into a "*drunken stupor*"), but also managing emotional and psychological problems, dealing with craving but, at the same time, being able to function at some level is remarkable. This is perhaps why Vaillant (1988) describes the process of addiction as, "ersatz employment," a theme developed by Wasmuth et al.,

(2013) who posit that addiction-as-an-occupation becomes the sole, self-organising activity and a meaning-generating routine of an alcoholic, so that the notion of moderation is anathema. It must require vast amounts of energy at a time when he is being physiologically weakened by the volume of alcohol he is consuming. He is again referring to this process in the third person. It may not be his actual experiencing, but it is a way of making sense. On two occasions he has described something obliquely. Perhaps he does not have to describe events in a way that makes perfect sense, provided that the general tenor of the description "fits" the events in some way, or legitimises to himself the actions of the past seen through the lens of the present.

The balance is drinking, but not to be drunk (or falling down) and to moderate the pain/fear and still function. This would be a state of day-to-day normality. Alcohol/relapse as the anaesthetic.

Perception: P1 uses this word twice in his narrative and in both cases he uses it to describe his view of himself and the effects of his actions as being simply an illusion and figment of his imagination. Whilst Lee Atwater is, originally, credited with saying that "*perception is reality*" and idea picked up by Carl Rogers (1951, 1959), P1 (in recovery) seems to learn that his perception is not real. It is a product of his mind which skews the evidence of what is actually happening from what he perceives things to be happening. See lines 547ff for P1's wider definition of the need to change this process if recovery is to be maintained. It seems to be one of the key mechanisms of recovery-maintenance.

There also seems to be a balance to be struck between both relapse-prevention and recovery-maintenance rather than, as the RPM suggests, just relapse prevention. The quality-of-life P1 enjoys in recovery comes from the personal progress he makes in self-awareness, competency in handling situations differently and achieving better results. It appears more to be satisfaction with life rather than quality-of-life.

The second negative view of relapse

Once the initial ingestion period is over a second phase begins. This is characterised by craving. This is the apparent need to drink in order to maintain a level of alcohol in the system sufficient for an alcoholic to believe that he is functioning like a normal

person. He may or may not appear drunk; that is not at issue here. What is important for P1 is that he believes (or he perceives) that no-one suspects that he is drinking. This is a crucial point. The ATRF would classify this as an alcoholic drinking sufficiently to stave off aversive effects of withdrawal (Bergmark and Oscarsson, 1987; Morgenstern et al., (1994); Piccinelli, et al., (1997); Babor et al., (2001); Holden, (2001) and is a definition of dependence (ICD-10). But for P1, the reason for continued drinking is to maintain a level of alcohol within him sufficient to function and at the same time avoid the fear of discovery. Emotional pain caused through specific stressors or accumulation of stressors becomes secondary to the anxiety of not being able to drink and appear functioning and drinking too much and appearing drunk. Maintaining a fine balance or level playing field becomes stressful in itself.

Appendix 13:

Example of the different formulations of metaphor and their use (P1)

The Narrative Method

There is one principal literary device he used within the context of a narrative method which reinforces the legitimising process; *metaphor*. Whilst he is keen to evidence his acceptance of the AA message, he can demonstrate his independent and personalised acceptance of it through their use. Though he uses the medicalised word "*symptoms*" (P1: 547) to describe the effects of alcoholism and describes his use of alcohol as a form of "*medication*" (P1: 71, 289) he eschews the words illness and disease completely. So whilst it may be wrong to suggest that P1 attributes his behaviour to a medicalised condition *per se,* his narrative employs a combination of powerful AA-derived and eidetic metaphors both of which are implicitly suggestive of an inequitable struggle over the mastery of the "*self*" (P1: 559, 587) and an external force of some kind. As with *The Big Book* of AA (1976), he describes what it is like for him to be alcoholic and particularly an alcoholic who relapses. The metaphors are of two types; those borrowed from AA and those personal to the narrator.

AA Metaphors

These metaphors, perhaps, demonstrate his adherence to the framework of AA. His use of thirteen AA metaphors includes:

- **four hideous horsemen** (P1: 2; AA, 1976: 151): this contrasts the power of relapse/alcoholism and simultaneously his powerlessness in the face of his condition. It also suggests that relapse is an all or nothing event of horror. He cannot control these demonic forces once they are unleashed. The outcome will be one of apocalyptic destruction. In the context of this passage from *The Big Book*, (AA, 1976) an alcoholic is described as a shivering denizen of the mad world of King Alcohol. The horsemen represent the sordidness of alcoholism,

how it affects an individual and are named as, "*Terror, Bewilderment, Frustration and Despair*" and also represent the black loneliness which accompanies drinking. But apocalyptic times foreshadow the arrival and founding of a new Spiritual Kingdom. So whilst apocalypse powerfully indicates the destructive nature of relapse, it also indicates the corollary of a sustained period of enlightenment and sense-making which incorporates his own spiritual renewal.

- **an alcoholic fashion** (P1: 39): a metaphor which encompasses not only the volume of alcohol consumed, acknowledging the phenomenon of craving, but also adverse changes in his personality and the lengths to which he will go in order to obtain and conceal drinking. It signifies an acute difference between people who drink socially or with restraint and those who cannot help themselves around those stressors which lead to consumption or any inhibition, once drinking has recommenced. Though not directly quoted in AA, (1976) it represents the taxonomy of alcoholism described in the "*Doctor's Opinion*" (AA, 1976: xxiii-xxx) and "*Bill's Story*" (AA, 1976: 1-17) identifying the specific relationship an alcoholic has with alcoholism.
- **unmanageable** (P1: 180; AA, 1976: 59); drawn from Step 1 of AA ("*Powerless and Unmanageable*") the metaphor encapsulates not only the way he tries to live a "*normal*" life and function, but the consequences or results which ensue from daily living with alcoholism, i.e. employment problems; physical ailments; family disruption; etc.
- **fear** which he uses twenty five times (P1: 54, 60, 72, 270, 286, 287, 288, 289, 301, 302, 303, 305, 315, 323, 343, 367, 368, 371, 372, 383, 390, 397, 399, 547, 638) is also cited within AA, (1976) 27 times. This represents his daily state-of-being. Fear is a metaphor covering a broad *aegis* of negative emotions (see below). It can involve the fear of relapse; mental and physical fear of drinking; the fears of others for the welfare of an alcoholic; fear of consequences which can lead to temporary cessation; equating to feelings of uselessness, depression and misery; fears of life which act as stressors; fear brought about by low self-esteem; fear of being revealed as an alcoholic.
- **the shipwreck and the lifeboat** (P1: 640; AA, 1976: 17) represents the refuge he experiences once he has secured his entry to AA. The shipwreck represents

his alcoholic lifestyle and the lifeboat the egalitarian, empathic, non-judgemental, supportive and welcoming refuge of AA and the salvation which it offers. The lifeboat metaphor was created by the co-founder of AA (Bill Wilson) and comes to represent the offer of salvation from alcoholism as well as the solidarity, trust, security and succour which the AA life-style offers. It is within the lifeboat where P1 learns gratitude, hope and the experience of what it means to be part of a family of recovering alcoholics.

- **clamours of life** (P1: 268; AA, 1976: 13, 98): these are the internal and external forces which prevent him following a sense of spirituality and communion with the Transcendent. This may be materialism, but also those factors which serve as his specific precipitants to relapse.
- **functioning** (P1:76, 312; AA, 1976:92); describes his inability to exercise "*normal*" will power and restraint, but is the complex way in which he tries to appear sober, yet consume alcohol at a level in which he is still able to receive the effect he seeks. Functioning may involve the pursuance of daily tasks without appearing intoxicated, but may also indicate the need for alcohol in order to feel physically and emotionally motivated to achieve those tasks. It is a complex metaphor.
- **fellowship** (P1: 672; mentioned 20 times within AA, 1976); this encompasses the universality and collective nature of AA which recognises no differences between race, colour, creed, economic, gender, educational or any other distinction between its members. It is the core element of an egalitarian community of self-helping men and women who share the common, self-labelled problem of alcoholism. It stands for the unity of the organisation and the shared belief in what it means to be alcoholic. It also recognises the need to evangelise the message of AA to those who need it (Step 12).
- **camaraderie** (P1: 639; AA, 1976: 17); is the joy and democratic nature of AA. P1 experiences "*camaraderie*" as a direct result of being part of a fellowship. It is an essential outcome and feeling of hope. It is also the antithesis of stigma, where an alcoholic feels welcomed to a group experience of mutual trust. It is indicative of expressions of love and the lengths AA members and P1 will go, to help those who are struggling.

- **passing the message** (P1: 622; mentioned 10 times in AA, 1976); this is the ultimate purpose of any recovering alcoholic and involves carrying a message of salvation, that there is a way out of the misery of alcoholism. It comes only as a result of the spiritual awakening in Step 12. He passes this message of hope in recovery onto others both by his way of living in recovery, but also by explaining the teachings of AA to others with reference to his and their personal experiences. The experience of relapse plays a part in acting as a warning to others and a motivation to remain abstinent.
- **one day at a time** (P1: 638); though not quoted in *The Big Book* (AA, 1976) it is quoted in the "*Just for Today*" card which AA members may carry with them. This metaphor suggests the need for him to stay sober for today in order to simplify his life and not become overwhelmed by thoughts of the future, or past. It is a technique for achieving balance and personal perspective.
- **way out** (P1: 622; AA, 1976: 17, 147, 153, 155) a metaphor which does not necessarily suggest that AA is the only means of accomplishing recovery or tackling alcoholism but offers the hope that, for those who choose its path, AA offers a lasting solution to alcoholism.
- **spiritually fit** (P1: 149; AA, 1976: 100) is the state where he has to review, honestly, his motivation and whether he has a legitimate reason for being in the proximity of alcohol or being around those who consume it. Being "*spiritually fit*" equates to the developing of self awareness and taking personal responsibility for one's actions.

Overall, P1 uses AA metaphors to highlight the horrors of relapse and the fact that he believes that the solution to his problems is provided by his affiliation with the tenets and precepts of AA and a daily need for a close association with its members (P1: 639). This is not to describe or lessen the validity of those experiences by a process of reification (Caldwell, 1990), or to assume that these metaphors mean the same to all those who experience of relapse. From the outset, he is at pains to make clear that he is talking only about himself (P1: 29, 246, 280). For example, *the clamours of life* (P1:268) whilst originally used by the co-founder Bill Wilson in his autobiographical account of alcoholism in Chapter One of *The Big Book*, it is metaphorically used by P1

to describe those *specific factors* in his life which he perceived precipitated his relapse. Relapse for him was terrifying and not a reified event.

They also serve to reinforce the model of alcoholism which AA views as an illness of the soul, or spirit (P1: 149) caused through an introverted and overbearing sense of ego and self-obsession (P1: 207). They equally provide a window into the daily life of any alcoholic who has to balance not only the problems of drinking but also the need to appear sober, in order to carry out (or function) in his daily duties as husband, father and employee.

Additionally, they indicate the stress inherent in balancing on a tightrope which he has to walk in order to drink the right amount of alcohol, so as to get the emollient effect which he seeks, but not so much that he becomes intoxicated and so gives the game away, or experiences the aversive affects of withdrawal. This was reinforced by the personal metaphor of *moderate drinking* (P1: 296):

"P1: ....my drinking was never to oblivion and fall over and go to sleep. It was a case of, which sounds ridiculous but, moderate moderately drinking all day, keeping myself at this level where the...

R: Topped up?

P1: Topped up" (P1: 295-299)

Yet his functioning, or the ability to control alcohol consumption, is impaired after the first drink (AA, 1976: 92), so that his drinking in an *alcoholic fashion* (P1: 39) does not simply mean the two bottles of vodka per day he drank (P1:42) or the lengths to which he went to conceal his drinking:

"P1: ...so then Saturday night I would probably say I don't feel very well and I'd, I'd feign going to the toilet with diarrhoea because then I could go into the bathroom by myself and I knew obviously where I'd hid the booze so I could have a couple of more drinks..." (P1: 337-340),

but the effect he believed that it had on his personality, thought and behaviour:

"P1: ... 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 there in (snaps fingers) just like that....you go back to an arsehole in the blink of an eye." (P1: 546-553)

AA metaphors indicate that recovery, for him, is an on-going, daily process for which there is no cure and that, as a result of a spiritual awakening as suggested by the 12-Steps (Step 12), his primary duty is to evangelise the message of AA to other still suffering alcoholics and materially assist in their well-being:

"P1: To see, er, you know somebody that you know you have helped and they smile, it's fantastic to help another human being...." (P1: 666-668)

Whilst these metaphors convey the power of addiction they also reinforce P1's experience of the sense of hope and self-efficacy which AA affords.

Personal (Eidetic) Metaphors

P1 is also adept at developing eidetic metaphors of his own devising. This second set describes: his existential life as an alcoholic; his personal journey from addiction into recovery; and the abject misery and pain which relapse caused and what that means to him.

Metaphors include:

- **the purpose of his active drinking and trying to function**: level playing field (P1: 68, 187); level (P1: 70, 75, 297) or baseline (P1: 187); self-medicating (P1: 71)
- **the emotional effects it caused him:** emotional roller coaster (P1: 92); pin ball machine (P1:93); the hole (P1: 94); black bin bag (P1: 203); hopeless place (P4: 154, 156); loss (P1: 57, 60, 360, 564, 584, 585); ball of string (P1: 194/5, 202, 243)
- **the benefits of drinking**: self-forgiveness (P1: 271); relief (P1: 268); self-medication (P1: 74, 289); oblivion (P1: 198); elation (P1: 367); the key to feel better (P1: 110)

- **the spiritual effects of relapse (negative):** lost soul (P1:61)
- **the spiritual effects of relapse (positive)** elation (P1: 367), big, full and rounded (P1: 626)
- **the somatic experiencing of relapse**: hole in the chest (P1: 288); cycling (P1: 366); emptiness filled with fear (P1: 288)
- **the struggle against alcoholism**: fighting (P1: 435); game (P1: 161)
- **loss of control:** button (P1: 157), switch (P1: 614), the line (P1: 275/6), wraps up and rolls over (P1: 372)
- **the nature of being alcoholic**: default setting (P1: 404)
- **the purpose of relapse**: end game (P1: 229); acceptance (P1: 432, 437, 507, 516, 522)
- **the strategies for staying sober:** the mechanics (P1: 572); keeping my guard up (P1: 493); 52/48 (P1: 76, 89, 90, 112, 113, 274, 493)
- **the safety of AA and its teaching:** straight lines (P1: 551); good thoughts (P1: 551); end and start points (P1: 551), acceptance (P1: 432, 437, 507, 516, 522); proof of life (P1: 659, 661); reflection (P1: 654); the way out (P1: 622)
- **the nature of recovery**: fragile/fragility (P1: 496, 504, 569, 570, 637); relapse area(P1: 494); okay (P1: 522, 536); the gap (P1: 540, 542); moving on (P1: 112, 480,)

He ventures onto the emotional roller coaster of life (P1:92) but then, like the ball in a pin ball machine (P1:93) he is buffeted by the exigencies of daily living and ends up down the hole (P1: 94). This hole is a place of despair (P1: 95), hopelessness (P1: 97) loss and loneliness (P1: 585) over which he has no control. Life is a daily fight (P1: 435) a contest which he loses, because he, initially, relies purely on self-will. This is brought about by the fact that he constantly strives to be perfect in the eyes of others (P1: 514) and has to succeed in all that he does (P1: 58). He comes to believe that he cannot manage his own life (P1: 180-1) that he is guilty of failure (P1: 590) which is unacceptable to his view of himself (P1: 522). Life becomes a quotidian struggle or fight as he rails against the perceived injustices he experiences (P1: 560).

Alcohol becomes a form of self-medication (P1: 74, 289), a temporary respite or relief (P1: 268) from the stress (P1: 549) of being who he is and the perceived negative

stressors of life events (people, places and things P1: 208). Crucially, although alcohol will make him feel better (P1: 110), he knows that it will not solve his problems. It is the expectancy of the benison of alcohol to take away emotional pain (P1: 66) which causes him to seek out that hopeless place (P1: 154) and conditions what will happen next.

Isolated and fearful, feeling like a lost soul (P1: 61) he seeks the comfort of emotional numbness which he terms oblivion (P1: 198), paradoxically that comfort is sought in this hopeless place (P1:154) because here he can find immediate forgiveness of self (P1: 271) and a freedom from personal guilt (P1: 591). The urge to drink overrides any fear of the consequences (P1: 476), he shows no ambivalence or hesitation in buying alcohol (P1: 22), yet he is aware that his relapse will increase his emotional pain (P1: 315) so that he is torn between the need to drink and the understanding of what will happen afterwards. At the moment of relapse he can see no other way forward (P1: 59), yet as soon as he begun to consume alcohol, the speed at which he returns to his old alcoholic-self surprises him (P1: 545ff). He is faced with the reality of what he has done and the relief gives way to mixed emotions (P1: 270) including remorse (P1: 32) and ultimately a feeling of loss (P1: 57) and feeling like a lost soul (P1: 61). This is followed by the return of painful negative feelings of horror, fear and self-recrimination (P1: 269).

That is the nature of being alcoholic, it is like a default setting (P1: 404) or switch (P1: 614), or line (P1: 275/6); it is the Rubicon over which, once crossed, there is no return. One drink is never sufficient (P1: 40) and he now drinks until he can physically drink no more (P1: 44-46) and it is this which causes the relapse to end. His decision (P1:273) is to drink, it is volitional, nor does he exercise any control to stop it; cessation, for him, is a physiological necessity.

P1 suggests that the experience of relapse needs to teach him two essential lessons. First, that this point in his life must serve as the end-point of his drinking life (P1: 229). It is against this backdrop (and all that has gone before) that he can contrast his current life of recovery. Secondly, that whatever may befall him in the future alcohol will not solve his situation, but will only provide temporary relief as it, "*takes away the pain* " (P1: 66), but then the fear and emotional pain returns "*tenfold*" (P1: 315). He is wrong to believe, as he has increasingly thought, that he can manage his life (P1: 181) through drinking. His life can now be managed with beneficial results through

following a 12-Step Programme of living. The improvement in his life may be slow and gradual but above all provides purpose with concomitant improvements in cognition and behaviour.

"P1:....I had somewhere to be something I could do, a beginning and an end, I could see a way forward and, er, it, it improved but the key to that was it would improve for today and then in the following day it, it improved just a slight, just a slight amount and one of the guys who helped me who sponsored, he said that even if you only improve a millimetre a day it's always in the right direction, er, and as it suggests in The Big Book we're not looking for perfection we're looking for improvement, er, and I try and do something to improve that every day" (P1: 446-452)

Metaphors provide an insight into the emotional struggle and personal battle which he has fought and now won. They rationalise his seeming loss-of-control over consumption, his attempts at functioning with alcohol and its use as a coping-tool and his nature ("*default setting*" P1: 404) as an alcoholic which sets him apart from other people. In this sense they also explain his cognitive processes whilst in active-drinking which lead to errant behaviour, but also his way-of-being in recovery. Above all, they seek to convey to others what it is like to be alcoholic, the destructive emotional, psychological and above all physical effects of drinking and provide not only the *raison d'être* of why he chooses abstinence and the form of recovery that he does, but why he is now deserving of forgiveness.

In short, metaphors reframe his experience, making it more acceptable to him:

"P1: (Pauses) It's accepting myself as well, that for whom I am and the type of person I am,..." (P1: 513)

Appendix 14:

Extracts from my relapse research diary/reflexive journal

14/2/14

The link between alcoholism, relapse and craving appears well established in the bio-medical field. The idea of motivation seems to be linked more with recovery. Cues which stimulate relapse seem to be mainly visual and olfactory, but there needs to be some thought given to people, places and negative emotions. The whole area appears fragmented and over-complicated.

I might try:

- alcoholism, relapse, craving, cues OR tolerance or stress psychology
- alcoholism, relapse, craving, negative affect
- or, alcoholism, relapse, craving, negative-affect, self-efficacy

The wholesale adoption of the disease model of addiction proposed by Jellinek (1960) and the development of neuro-imaging since the 1990's has meant that the bio-medical world has come to view the phenomenon of "craving" as having particular significance in the treatment of addiction relapse. The link between pharmacology and psychosocial interventions is a mercurial one, as it does not seem clear whether this symbiosis has arisen in compliment to the field of personal therapy, or as a result of any therapeutic success/failure at attenuating relapse.

What is becoming clearer to me is that the two themes of "craving" and "motivation", which I originally discovered in my Google search, are split between these two arms of treatment. Motivation lies firmly within the therapeutic camp and is grounded in the area of motivation-for-recovery, whereas craving rests in the bio-medical field and is linked to relapse, i.e. a desire to drink. As with most ATRF terminology "craving" has no clear definition; either it relates to a return to drinking post-recovery and the mental cues and triggers which a recovering-alcoholic needs to manage to prevent relapse, or it means the inability to stop once an individual has begun to drink. From my clinical practice craving relates to post-relapse drinking, whereas the thought of wanting or needing a drink (pre-relapse) would be termed obsession.

What I am struggling with is how far to incorporate the bio-medical wing or just acknowledge its presence and then set it aside. But this does mean ignoring a whole chunk of research which might be relevant. I will not know until the interviews have taken place.

Also, distinction might have to be made between mental cues and "triggers". Mental cues are the reactions of an individual to stimuli from the senses, most notably visual and olfactory (though not auditory, I wonder?) acting on the brain. Triggers are responses to stimuli from people, places and memories, a la recherché de temps perdu.

6th June, 2015

I am still not happy with the literature search. The ATRF views relapse as being caused through a series of confounding variables for which the RPM devises strategies of attenuation. This is allied with an outcome-goal and a desired quality-of-life which is the choice of an alcoholic. It is curious that the professional does the diagnosis, but then leaves the rest pretty well to the patient; why? In other chronic illnesses (e.g. cancer) a patient may simply want to be free from cancer (i.e. sober). That is reasonable and I do not think for a moment that if they had a choice between living high on the hog and yet still knowing cancer was lurking within their system ready to flare up and living on the bread-line but knowing that they were completely free of it that they would choose the former. They would always choose abstinence.

What I have been searching shows the perceptions of what causes relapse; there does not seem to be a definition of what relapse is, or how it can be measured. All the studies, with a few exceptions, draw their conclusions from addicts (alcohol and other things), based in the US, measured over the course of a year and then pre-suppose that these findings from in-patient treatment centres apply to alcoholism. They may apply to the participants who engage with these studies but they may have little relevance to those in recovery. In other words, conclusions drawn from someone sober for 6 months may be materially different from the same person 4 years later. I am looking in the wrong place, but I suspect that there is no right place to look as the ATRF simply does not have this kind of data. For the time being I will leave my

research data where it is, but at some point I will narrow this down to purely longitudinal studies and see what this reveals.

13th April, 2016

I have just written the following to my supervisors:

"I have been thinking about our conversation regarding interpretation and have returned to trying to clarify what I am trying to do. On several occasions you made the distinction between the work of a therapist and the work of an academic researcher. I am comfortable seeing myself as a psychotherapist it is, after all, what I "do" for a living. Mercurially, perhaps, I struggle to see myself as a researcher/academic as this is a new world to me. I am a therapist who is especially curious about an aspect of his work. I have the time, money and (it seems) the ability, thus far, to pursue that line of enquiry in an academic setting and without ruffling too many academical feathers!

In my work, I listen, reflect back, paraphrase, sometimes reframe what is said to check for accuracy, I will often make congruent statements about what effect a patient's narrative has had, in that moment, on me. But, I am doing all this not for my benefit, but so that a client , hopefully, becomes clearer in his/her own mind about what s/he is first saying, thinking and finally meaning *to him/herself*. As such, I hold up a metaphorical mirror in which they can see themselves and see how they have, in that moment of encounter, made an impact on me. If they find it useful/helpful/reflective they can accept that, if not, chuck it in the bin. What I am trying to do here is not interpret what they are saying, (i.e. make meaning of it, because that is what their stories are doing already), but represent what they say (for some reason the word *distil* keeps popping into mind) so that their voice, their word-picture even, can eventually be shown to others, like me, who work in the field of addiction, but rarely ever hear that voice, or see that image. If I have not got that representation to the point where they can give their willing assent, then it should not really have a place in the study. So I believe that it is necessary to show my written representation to them, because that is an essential part of the data.

The reason for this is that I am conscious that these participants are a group of men and women (hopefully) who guard their anonymity and rarely speak outside the

confines of their organisation. So I am mindful that they are being brave enough to step far outside of their normal comfort zones and are placing a great deal of trust in me to reflect, to the outside world, what life with relapse (and alcoholism) is truly like. Not to offer back to them my representation of their words, strikes me as somewhat hubristic and places me in the uncomfortable position of acting like some *Deus ex machina,* whose judgement will now be accepted as the arbiter of what and how their stories will be interpreted.

Instead, I hold up to them the reflection of what they have said and once I/they are assured that *at this point* we can agree that it is as accurate a reflection as we can jointly make it, then we can turn the image round and show it to the world. That for me is co-construction and the validity of my study will come through the explicit sanction of the participants. So, if my representation is rejected then it is *mea maxima culpa* and I have to go back to the drawing board and start again. It is a risk I am prepared to take and perhaps one of the perils of working with such a cohort of participants and why, to date, few do!

One of the more disturbing aspects of the research of alcoholism is that there is a serious power dynamic. People seem to be viewed as objects to either prove or disprove a theory; the therapist is expert and it is he or she who will interpret their participants' findings. Rarely will there be an input from the participants beyond their rôle as data providers. Even those researchers who are pro-AA, such as Kelly, are looking at the mechanisms of how it works because the argument of the ATRF is that unless it can be proven to academic researchers that there is something here that works and can be demonstrated to work (empirically) then it is not valid.

But reading the transcript of P1, he does not need proof of the mechanics because these are only a small part of the problem; it is the feelings and orientation of self which is important. He believed that alcohol was valid and he believes that AA and his new way of living life is valid; he may be wrong, he can admit this. I am interpreting a person's interpretation of the circumstances of his life which he admits is faulty. AA itself is an interpretation (based on personal experience) where a person with alcoholism will accept it as being real because the pieces (or as many of them as are necessary) fit their experience, or at least offer an explanation to them. "I could not

stop drinking, even when I genuinely wanted to, becomes I must be powerless over alcohol. My life turned to hell in a hand-basket and other people needed to step in to sort things out" which is transformed into " I was powerless over alcohol. My life was unmanageable; the alcohol dictated what I was going to do on a day-by-day basis", i.e. AA's Step 1.

It comes as quite a shock to consider whether I have been as guilty as that which I find objectionable in researchers. I have assumed that a problem (relapse) can be understood by looking at what was done, what happened (the antecedents) and then seek to define alternative behaviours, different acts which then alter the outcome. In order to avoid getting wet next time, Dr Foster, try going to Lincoln instead and when it is sunny. The struggle for me at the moment is to decide which I am researcher or therapist. It is whether I am planning on following the herd in objectifying the participants and thereby losing some of my humanity and potential understanding of relapse, when doing so?

Preissle:

"…we are studying ourselves studying ourselves and others. If we can no longer use detachment, distance and neutrality to achieve objectivity, we can at least document and track how what we study is influenced by who we are." (2006:691).

But if it is not what I am studying then what is profoundly influencing me? My practice is misdirected!! P1 has opened up a new world of insight for me. How easy would it be to regard his relationship with alcohol in terms of maladaptive attachment and so bolt on Bowlbian theory. Or may be accept that he has learned, over time, to condition himself to drink as a means of coping (enter Bandura). It is almost too comfortable to roll out the appropriate received wisdom as a point-of-reference so that we can better understand or appreciate what is under review. There is also a point that seems important here. What is being explored is something that is fundamentally a *pleasure gone wrong*. While IPA may reveal much about phenomena such a motherhood, or experiences of life stages, what this study attempts to explore is a phenomenon which is viewed by those affected by it as destructive and by the person doing it as illogical and damaging. It is a wrong-doing compounded by a wrong-doing, or double moral-failing. Alcoholism is not devoid of moral censure and stigma."

25th May, 2016

If I achieve objectivity, do I lose some aspect of humanity and compassion for someone's tortured suffering? Does the relapse become less real, less immoral? I do not want to achieve distance (bracketing) because I want the participants (my fellow researchers who have selflessly deigned to co-operate with me) to draw me in, so that I can experience the "as if". It's closeness I seek, not looking from afar. This is the problem I sense with most of the research I have read to date. So many of these papers reify relapse and the suffering of others becomes relegated to little more than something to be studied and picked over". There is a real anguish and pain which is dissolved into trying to find the prototypical exemplar of what is alcoholism or what is relapse. How and where does it fit on a sliding scale? How can we place it on a graph or bar chart? Can it be codified?

7th August, 2016

Tonight after it went dark, I went back to reflect, yet again, on P1. I assumed the rôle of someone trained in the Stanislavski method and sat out in the garden. I was trying to recreate lines 341-350 in my mind and to imagine what it must be like for someone to sit, intoxicated outside in the night, swigging from a bottle of neat vodka as the rain is falling on him; getting wet; shivering with cold; hoping above hope to get pneumonia and die because he is experiencing such a profound sense of loneliness, failure and contempt for himself and what he has become. Too terrified to commit physical harm to himself and end his own life because of the fear of judgement from his God, but too lost a soul, too despairing, remorseful, ashamed and emotionally beaten to want to live anymore.

This man's hopes are dashed; what he had planned, dreamt and striven for lies in ruins; the image of himself that he has painstakingly tried to construct is shattered. He is sitting with the fact that he has crushed the love out of his daughter and wife and now views someone dying of cancer with envy because that person is getting attention, love and care and he isn't. He is actually jealous of someone dying of cancer! How desperate must a person become to be jealous of someone fighting for his life with a terror of terminal illness?

Instead, he feels the coldness of his family's rejection of him; the disapproving glances, looks of pity and loathing. He has become a figure of ridicule and disgust. His mind is a-whirr with bitterness, regret, shame, frustration and the knowledge that all that was asked of him was that he didn't get drunk, vomit, shake, sweat, stumble or hallucinate. That he did not feed them a seemingly endless and wearying diet of lies and deceit; did not embarrass them socially; get aggressive when they tried to manage his drinking and remove the harmful consequences of his behaviour; cover for him; have to make excuses for him; lie awake at night sobbing and worrying, wondering where all this was going to end and would it ever end?

Living with a constant walking-on-egg-shells and the knowledge that people talked about him in whispers; the family with the drunk for a husband; the daughter not daring to bring back her friends for a sleep-over or just to spend an evening in her bedroom doing what young girls do. And why? In case dad gets utterly smashed and shows her up in front of her girlfriends; she's *the-girl-with-a-drunk-for-a-dad*. But that expectation was too much. He hated the drink, but he had no choice, he had to drink, he felt compelled. Why? Is this his phenomenological description of his brain's activity surrounding loss of inhibitory-control? This is not an excuse, he genuinely believes this. Yet, at that time, there is a part of him which knows that all this is his fault, if only he can stop drinking. So he sits as his pyjamas are soaked through, bitter and wallowing in self-pity, baffled as to how he has let his life come to this. He has had four years now to devise some argument or rationale which can explain his behaviour. And the best that he can come up with? It was all part of an end-game! It is feeble.

I am profoundly affected by the first transcript, not just the honesty and brutality of what is being said to me, but the fact that, as with the other participants, a complete stranger is willing to open up to me in this way. This is me being interpretive and adding many more dots than are in the text. So am I studying this like an entomologist studies a beetle? Or am I able to be open enough to experience this for the tragedy that it is. Does one study human tragedy? Is this social science, to map out a course of self-destruction and categorise it neatly into a set of themes? Or is that simply an act of gross discourtesy?

Is this the study of ambivalence and how someone is able to experience the illogical and inexplicable and yet manage to make something positive emerge from it? I am strong because I can admit a weakness. I am in control because I admit that I cannot control. My practice of immorality demands my morality. I have freedom of choice, by not exercising freedom of choice. My sanity is proven by my experience of insanity. I understand by not understanding.

13th September

I notice that papers often say "the" alcoholic" or "the" addict and I also notice that I do the same. Should it not be "an" alcohol or "an" addict, or are we automatically assuming that what typifies one typifies all? I will pay attention to this as it seems to be the difference between a researcher and a person-centred therapist. Do I use "the" when in researcher-mode and thereby distance myself from a participant?

15th September, 2016

In Heideggerian terms is the *object* alcohol and perhaps the *intention* the relationship with alcohol and how alcohol fits with a person's identity and the changes it effects? It is difficult to explain in cognitive or behavioural terms the insistence that an alcoholic has that the effects will always be either beneficial or that he/she can control these effects. The relationship therefore becomes one of beneficence. The desire is always to be or feel better never to cause harm. This is the plan or outcome expected.

Alcohol is used as the regulating thermostat of emotional control. It moderates the intensity of negative feeling, bringing it back to a via media where emotions are felt to be under control or at least pleasant and acceptable.

24th October, 2016

I have been asked to consider in what sense is my study phenomenological?

Phenomenon: something which exists and can be felt, seen, touched, tasted, especially something unusual or interesting. (Cambridge Dictionary on-line)

It seeks to understand the experience of an event and to view that event through the eyes of the main protagonist. To try and get as close to the actual experiencing as possible, perhaps, as if one was there. The phenomenon exists as an historical event which was experienced. So much is fact, so much is fiction and I say fiction because it relies on the memory, linked to an interpretive account of the event which is presented by a combination of both recall (or memory of the event, which is in itself an interpretation) and interpretation or representation from the current stand point of where the narrator exists at this moment. The narrator is presenting a view of an historical factum from a vantage point of his/her understanding and how he wishes to present his/her current and historical self. So the story is a portrayal of how a person sees him/herself and that stands in relation to an historical fact. It is one and the same person, but it is a materially different person. The relapse served as a crucible of change and it is through that experience which an alcoholic hopes and believes that he/she has changed permanently.

One is never going to truly see the experience as it was, as the narrator cannot remember the experience as it happened; in hi/her mind is left only the imprint of the event. But by sharing his/her recall of the event potentially some of the definition which has been lost in time can be recaptured, or reconstructed as a facsimile of the experienced event.

In other words, the story goes:

"I am an alcoholic, but I no longer drink and can term myself as one who is in recovery. I would not now choose to relapse. However, once upon a time, I was an alcoholic who hoped not to relapse but did. Why am I not that same person? The answer is that I have learned something about myself, through the experience of the relapse. It was through that experience that I changed to become the person I am now. However, I find myself in a difficult position. I cannot remember the event with any precision and my memory of it may well be affected by alterations of pertinent details because I now view the relapse through the lens of recovery. To keep me sober, I want and need to view it in the way I am describing it. The position is made more difficult because relapse *per se* is a negative nonsensical act. It serves no useful purpose; it derailed my initial recovery. But, as with any mistake, it is possible to learn from a mistake, to imbue the error with a meaning or discern within the catastrophe

some benefit which reshapes the disaster into a benison. This may be factual or it may be an interpretation, I am not sure, but it is the way in which I currently choose to make sense of, or make acceptable, a negative event.

There is a tension in my narrative. I wish to portray an image of myself (as I am now) and juxtapose this with the person I was then. However, the act of relapse is not only negative but also carries with it serious doubts about my integrity; how do I excuse these doubts successfully?

The researcher is then trying to do what? Interpret an interpretation which is already distanced from the fact. Or am I trying to represent that interpretation. Why bother? Because there is a need to understand not just the act of relapse, but more importantly why some people appear to be able to use their experience of the event to remain sober.

It is not so much understanding relapse which is at stake here. It is trying to understand the process by which alcoholics interpret the phenomenon in order to secure recovery. This has clinical benefit.

By doing so, it may be able to scrape away the crustaceans and weed of professional interpretation of relapse amongst in-treatment subjects to discover some implicit details which have only, marginally, been apparent to the awareness of the narrator as neophyte recovering alcoholics. They have lived through the experience of relapse and emerged through the flames as radically altered people. My study is phenomenological because it seeks to study a fact or experience which has happened and for which there is, as yet, no clear explanation. The interviews so far fail to explain (and this is recognised by the narrators) why what happened, happened. By his/her own admission his/her account is flawed; but it works for him/her. S/he takes the experience and reshapes it so that it is both purposeful and conforms more to a potentially idealised image-of-self. Could this be replicated? Can you replicate an experience? No? But you could possibly re-phrase and represent the narrative in a way which views the phenomenon through a different lens or from a different angle.

If I am being phenomenological then the next problem I face is that the phenomenological methodologies I have read about all start from the point of the researcher knowing best and being the arbiter of decision-making. This cannot be

right as it is not person-centred, but is IPA person-centred? Followers of this method might say it is, but it is not in the terms by which I understand it.

Does a perspectival representation of a fact have any validity or usefulness? Its validity is no more or less apt for being my interpretation, but its validity is enhanced if the original narrator regards it as equally capturing the essential elements of what he/she is trying to convey. This is not to say that I am capturing the essence of the experience; that may be long gone, but it may fettle the impression of the fact that has been left behind. Is it like the residue of the Big Bang which cosmologists attempt to discern? It may help illuminate how a certain set of people think, feel or behave in different situations and how they ascribe a particular meaning to that experience.

As I write this I question whether this is science any more than Beckett's "Waiting for Godot" is a scientific study of time; waiting for God or waiting for death. It is a conceptual exploration of phenomenon, or an idea.

12th November, 2016

Do alcoholics make sense of relapse in the context of their own environment? i.e. in relation to families. There seems to be a gender difference; P2 will not directly admit that she made a choice, but she was reckless; she does this in an oblique way. P1 deliberately legitimises his relapse in the light of the present; i.e. it was worth it.

Both know that it is wrong, but both cannot cite any desire to drink as the root cause because to do so would cast them in a poor light. Not sure what I am trying to work out here. Relapse is not made sense of in isolation it is explained over and against something else.

29th November, 2016

Living in the world of social drinking is not easy for an alcoholic. When in active drinking, always feeling that you are in the wrong, or trying to keep the drinking under wraps is difficult:

"P1VT: Yeah, that that's very much just like being an alcoholic, is being, being caught, because you know you're already in trouble the majority of the time, um, and to be also then caught drinking or having drunk, er, but it's that all-consuming fear that I couldn't function, being so fearful every day... and the, the alcohol was medicating myself to take that fear away." (P1VT: 37-41).

But even when sober, there are triggers apparent in everyday life which the non-drinker simply takes for granted:

"P1VT: ... er, because the opportunity, alcohol is around us everyday... everywhere we go and the opportunity to drink is always there..." (P1VT: 164-166)

The act of socialising presents an ASR (which I am using as an abbreviation for an alcoholic in sustained-recovery) with inherent dangers and stress, so that simply having a good time becomes a minefield of temptation. . P5 voices this concern when she says:

"P5: ... in our social life in in my partnership with (partner's name), um, we go out a lot, er, it it had always been, um, er, drink on the table, um, it was very much part of our social set up, um, I, I think sometimes, um, 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: 131-135)

Being in a social environment, even though family and friends may take away the unused alcohol at the end of the evening so as not to present temptation to an ASR, still does not alter the fact that they have been exposed to this kind of pressure.

"P2: [I] 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." (P2: 10-11)

It is for this reason that P2 came to believe that even though she felt she was enjoying herself, the absence of relapse in her social environment triggered the idea to test whether it was possible to drink minimally, so as to maximise her pleasure even though she believed that she acknowledged wholeheartedly that she was alcoholic and, as such, drinking was not advisable:

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

The question that her non-drinking in a drinking environment posed was whether her contentment in not drinking when others did was authentic or not:

"Right, let's test this happiness." (P2: 246)

1st December, 2016

I am struggling with delineating that which is a representation of the experiences of the participants and that which is my interpretation. In listening to the narratives I am always conscious of what I am hearing, what I understand a participant is trying to say to me and the felt-sense, the somatic effect or impact of what is being said at any one time. But this felt-sense is an interpretation, because the impact of what is being said to me is, simultaneously, being interpreted. I cannot get away from this and I am not sure that I can "bracket off" myself as the therapist is always getting in the way, but this is authentic. I am not trying to twist what is being said in order to fit some preconceived idea, because I do not have a vision of what I think recovery might be as I am not a recovering-alcoholic.

This brings me to another point. Is it legitimate to create an aggregate experience of relapse from the participants, or by doing so am I creating nothing but a patchwork quilt of experiencing, because I believe that each piece of material (data) somehow fits with another in texture or colour. Yes I am creating an example of an overall phenomenon or series of phenomena into some type of whole, but this may look to be harmonious but is, in fact, nothing but a series of bits cleverly sewn together.

I must not lose sight of one fact; this research is an account of a series of individual experiences of people who have not met and so have no collective sharing of experiences between them. This is unlike ATRF research where the subjects are usually taken from the same in-patient treatment setting and know each other.

AA (1976) did this in a fashion, knitting together disparate experiences, but the person doing the sewing was himself in recovery from alcoholism. He stitched 100 experiences into a quilt which was presented as being representative of alcoholism; he

had to start somewhere. But how far can it be said that one man did the sewing and how far was it his decision to take the individual bits of data and fashion them as he did? Conversely, the participants I am speaking to seem to accept that, by and large, the quilt of AA is representative and does describe the phenomenon, broadly speaking, with a fair degree of accuracy. Or that there are sufficient pieces of the quilt for them to recognise a "pattern".

Each participant is describing relapse, but each description is different; there are commonalities of texture and colour but the sizes are not uniform. Bill Wilson achieved some uniformity, not to present a proto-type of an alcoholic but an indication of what it *means to be alcoholic*. Are my participants doing the same? Do I just need to present the various patches but not sew them together? It seems perfectly valid to represent different pieces of material because this is what each participant is bringing. But, what about the commonalities? Where do these come from? But in PCA terms they play a minor rôle. Each understands that they must not drink; all believe that change is necessary; all acknowledge that relapse can happen again if certain things happen or do not happen; all believe to some extent in the need for AA and a process-of-living or learning to live differently; all agree on abstinence. They believe in some essentials and they also agree to some degree in how this should be done (abstinence, AA meetings, change of self, 12-Steps), but they do differ in the *how*. It keeps coming back to process.

There is also the fact that this will all take time, but it is also confusing and they can accept this and will live with this. It is legitimate to represent the findings in the aggregate but it also must be made clear that this is a compound picture based on the material to hand. Like a stained glass window or quilt (all the experiences are colourful in a way) the picture that you can make depends on the people and also on the interpreter. Is it more legitimate to do the one and not the other?

But I am also hoping to compare what the participants tell me with what the ATRF holds for the same phenomenon, so that will involve interpretation. So far, though, the participants have said that I am representing/interpreting what they have said in a way that is accurate and true to their feeling and the impression that they wish to convey. If they want to convey an impression then this will demand an interpretation

from me. Provided that this interpretation represents their intent accurately, then this indicates the validity of what they said. After all, if Bill Wilson interpreted/represented what the first 100 recovering alcoholics said and they agreed then, if I follow a similar pathway, I am on safe ground. But I will never know what it is like, or get much closer to the experience as I do not have the tee-shirt.

2nd January, 2017

It is interesting to see how alcoholics view the rôle of autonomy (or is it self-efficacy?). On the one hand there is the first order view which sees a value in desire i.e. I want to drink versus the idea that values abstinence, i.e. I don't want to drink. So, perhaps, autonomy is the choice between the two. There is also the idea that I choose abstinence, i.e. I don't want to drink, because I know that this is the right thing to do, given what has happened in the past. Alcoholics hold both views, the latter especially in recovery as having an element of choice/self-efficacy, i.e. putting the autonomy into practise. But there seems to be a third order; I want to be sober because I am sacred of not being. It is not simply the right thing (socially or morally) to do, but like the diabetic who has no choice in not taking her insulin, an alcoholic volitionally elects (at the start of recovery) to stop drinking (because it is the right thing to do), but in time finds that staying sober is not merely right, but the benefits of so doing mean that it is no longer a hardship but does it as a matter of choice. As P5 says:

"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?" (P5: 315-316)

This may involve a fourth order view: I don't want to drink, even if the thoughts come into my head, because the life I now lead, how I view myself and the pleasure I gain from being me far outweighs anything which alcohol could provide (though I acknowledge that at one time it was my one main comfort and I puzzle over that!!). This kind of autonomy leads to freedom to grow in unimagined ways.

AA (1976) takes an aggregate view of the phenomenon of alcoholism which it presents as a composite picture of what it means *to be alcoholic*. It illustrates individual aspects of the phenomenon still further with individual stories detailing the specific life-

experience of a disparate view of people who all acknowledge themselves as alcoholic. The process of recovery, which is individual to each (e.g. P2 has regained her religious practise; P5 is playing the piano again) is both a cognitive and behavioural practise which is founded on morality.

They severally seek to find a formula for their recovery which can secure the end goal of a positive outcome. Each ASR seeks to garner a series of virtues (e.g. P2 honesty; P4, disciplined, persistent, consistent, respectful) which s/he practises on a daily basis. For P4 it is the practise of humility; for P1 it is altruism, so that whilst all follow a 12-Step programme they do so in a specific fashion which represents their frame of reference (e.g. gender, severity of drinking) and also satisfies their outcome needs.

For example, P1 wants to be good enough and help people get into recovery and share his pleasure; P2 wants to see unity in her family and not to cause them any distress; P3 wants to learn about himself and develop more self-awareness. P4 no longer wants to be seen as being perfect or honest, but to help others. P5 wants a freedom from a life of indentured servitude to conform to the expectations of others and stop playing the rôle of the “good girl”.

In one way, relapse is an irrational act, to return to drinking knowing what it has done to you. Yet it is a very human act to want to test the validity of a hypothesis, so that one has first hand experiential knowledge of what is going to happen. In one sense, each participant has no broad experience of recovery (whereas they have a lot about alcoholism). Viewed from the vantage point of recovery it is irrational, but from the actual point at which they relapse (i.e. with little or no experience of recovery) it is hardly surprising.

The transfer from active-alcoholic to recovering-alcoholic takes a long time, so that even at 2 years (P5) it is not a long time (within a recovery which will last a lifetime) to assimilate all that is necessary to attenuate relapse. This is especially true in there are still a plethora of unresolved issues which have precipitated drinking in the first place. It is a tall order to get someone to change after a lifetime of one habit to a new one in a matter of years.

Based on the figures they give us P1 drank for 14 years and relapsed after 7 weeks; P2 drank for 5 years and relapsed after 7 months; P3 drank for 20 years and spent months trying to get sober which he finally only managed when arrested; P4 drank for 12 years (or had 12 problematic years) and relapsed after 4 months. P5 drank for 45 years and relapsed after 2 years. P6 drank for 20 years plus and relapsed after 3 months. There are differences between each but the fact remains that they drank for a long time and secured initial recovery/being-sober for only short period of time AND they are using the golden rule of recovery that means total abstinence (and this is not always seen as necessary within the ATRF). But, they all take an uncompromising view which says that they planned or acted in a way in which drinking was irrational and morally wrong. Only two (P4 and P5) accept that this was planned. P1 knows it is wrong but simply succumbed to temptation because he was not feeling any beneficial effects within his recovery and had too many problems. P2 suggests that it was spontaneous and not planned, but agrees that perhaps she was getting complacent and this was a way of testing herself or a final search for "proof". In the search for proof, she is akin to P4 who did not want believe that he was an "alkie", whereas P2 believed that she fully accepted that she was alcoholic, but that somehow a "bit of complacency crept in". P6 just drank.

How can it creep in unless she (P2) was complicit in allowing it to? Here begins another phenomenon which goes someway into explaining a tertiary and somewhat "*mystical force*" (P3) which comes to play on an alcoholic's volition. Whereas P4 is adamant that spontaneity is never the answer but relapses are always planned (an act of autonomy) P1 takes the view that it is an eternal mystery which can never be explained, but only legitimised by the fact that he has remained sober. If however, he gets or allows himself to be in the position of making a choice between first and second order values then he will always drink; he will have no choice.

P3 echoes this with his belief in "*mysterious force*" which drags and drifts him against his will so that he has to avoid a psychological "*scary place*" because if he gets there that surround the hole of relapse and he will have no choice but to drink. P5 likens this to a "*place in my brain*" which will always determine that she will drink and autonomy will go out of the window. She will be tempted to drink if she stops heeding the warning of the bogey man on her shoulder. P3 metaphorically describes this as the

"*parasite*" which controls his thoughts and actions. P2 believes that she cannot come up with an answer as her act of relapse was so quick, but that there may have been a myriad of tiny contributions which lead to it. For her the question of choice is irrelevant; she drank one drink and it turned her into a mental "*basket case*" that is all she needs to know.

It is a bifurcated way-of-being as the participants believe that they oscillate between relapse and recovery during the day. P1 describes this in terms of the 52/48 % rule. P3 suggests that this happens when he gets angry (relapse). But who is the authentic self? For these participants they believe that they are alcoholic; this is the rôle of acceptance, i.e. to accept that their self-construct is that of an alcoholic and once an alcoholic always an alcoholic (Fiorentine and Hillhouse call this the addictive self).

An alcoholic can live in one of two ways, what P1 terms old behaviour and old thinking which is a particular mode of being which typifies this identity. P5 similarly refers to this as does P2 who states that as soon as she drank she went right back to active-alcoholism. An alcoholic self-overlaps and envelopes an authentic self, as P3 suggests, it is not that all his virtues are stifled, some remain, but they are suppressed and it is in recovery that these can begin to emerge from their dormant state. The second is an *aspirational self*, or being-in-progress. It is a person in recovery whom they seek to be and is evolving all through their recovery (P3's notion of learning about self). P6 sees this as being spiritual, even though he is clear that he is an atheist.

This is a combination of all the good parts of the old self, the suppression of the bad parts of an alcoholic-self as well as the new moral parts of a self which develops as a result of recovery. Hence P4 can claim that he is not cured but in remission and in recovery. Who is this person; first he or she is sober, secondly she is virtuous, moral, this a person of values which have been won dearly and at a terrible price. These two identities are reflected in all alcoholics, this is what P1 believes. The family of AA shares a common agenda (P2, P4, P5 and P6).

What affects the notion of self is not that an alcoholic wishes to discard his or her goodness or moral values. Initially, they believe that their lives and their way-of-being are improved and that they are better people (e.g. more confident P2) when drinking than not. But they will always have to contend with the power of alcoholism, (that is

why in Step 1 their powerlessness is acknowledged). For P4 this power means that he can view himself only ever as in remission, as to admit that he is cured could cause a return of the old self. So powerful is the influence of alcohol that P3 believes that if he genuinely accepted that he was cured, then somehow alcoholism (the external phenomenon) would twist this to its disadvantage thereby luring him back to drinking and the whole cycle would begin again. For P1, P2 and P5, the power of alcoholism is evinced by the speed and magnitude of the mental effect upon them and, in P1's case, the physical effects as well. I note that alcoholism is anthropomorphised or created into being some "entity".

All agree that there needs to be coping-strategies which delay or put some distance (P5) between an alcoholic and the drink. But each again interprets this in different ways. All agree that avoiding alcohol (eg by not keeping it in the house, P2 and P4 is essential. For P5 telling people up front that she is an alcoholic is her primary strategy. P3 would regard this as being a last resort but prefers to engage with a twice daily exercise of self-reflection. P2 employs her family and especially her husband to watch over her when out socialising, P4 will not go into a pub. So there is a composite story but at the same time each has his or her own way-of-being.

It is possible to assume that as all follow the teaching of AA the same findings would emerge from participants in Philadelphia, Lima, Peru or Preston, Lancs. But the important part of this study is that each interprets and actions his/her recovery uniquely. But they also at times will make pronouncements about alcoholism and recovery using the second person plural. This seems to indicate that they speak on behalf of AA, but will cheerfully move between the general and particular, for example:

"P1VT: ... Yeah, it's the immediacy of the relief from pain and tension and fear and all those things that grasp us during, during our day... um, and following the 12-Step programme has allowed me to, er, deal with those... things. Umm, for me I say this advisedly, "normally"... because I can now deal with them in an acceptable way... and that's an acceptable way to myself and the rest of the world." (P1VT: 218-227)

9th February, 2017

A reassuring article by Etherington (2009) on life-story research which states that people struggle to make sense of their past and create meanings as they show or tell therapists what happened to them. The researcher then tries to analyse or re-tell those stories and finds multi-layered complex patterns, descriptions of identity construction and reconstruction and evidence of social discourses that impact on a person's knowledge creation from specific cultural standpoints (Dalute and Lightfoot, 2004) and which resonate with each other. The telling of the life story has a recuperative rôle (Frank, 1974) and therefore, the telling of the life story becomes a moral (?)act.

I sense that this is what is happening within the stories I am hearing, as they reflect an individual's grasp on their life experience. That this has a healing property is voiced by P1 when he says, "*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 that I am today*" (P1: 387-388) and P2 states something similar. All participants have a life story which they tell to me (to others, P2) in order to remind themselves of what has happened to them. It is a concept of "narrative knowing" (Bruner, 1986). Perhaps the telling of a story to a researcher can often be more therapeutic than therapy itself, as it enables the narrator to make connections, through the questioning applied (rather than just narrating a story), this is because it is following the researcher's agenda. It also changes the power dynamic as a participant is giving something to the researcher (what he/she wants) rather than asking for help from a therapist. The story is central here rather than the collaboration between two people. Or the collaboration helps make the story, which seems more likely.

They are telling their story, but they are also aligning it with the collective story of AA which overcomes some of the isolation and alienation in their contemporary life. This is why P5 feels her sense of belonging with AA.

Another article by Owen-Pugh and Allen (2012) this time using grounded theory notes 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*" (Owen-Pugh and Allen, 2012: 269) and conclude that recovery may "best be understood as an identity

project (Blomqvist, 2002). But the participants are the same people, only different, which is what they seem to be saying.

5th March, 2017

In my opinion the difference between a person-centred therapist and a phenomenological researcher is that they are similar. There may be divergence in that the researcher will look for over-arching themes which could potentially be generalised to others, but the therapist is looking less for themes, but what he might call patterns. These patterns are not necessarily predictive of future behaviour, but do reveal something of the process of an individual. If the process is "x" then the likelihood is that the thought and behaviour will be "y". Another word for process could be way-of-being, i.e. this is how I am, or react, think and behave in any given circumstance because this is the person I have become. Each client is a case study.

18th, June 2017

The therapist is trying to understand, get inside the mind of an individual, by creating an environment of trust and safety where a client can be less defensive. Defensiveness prevents the essence-ness, or Rogerian "is-ness", of a person from being revealed because s/he is ashamed, uncertain, hesitant, their ideas are not yet formulated and there can be all sorts of different reasons. The therapist is interpreting what he/she hears, through empathic reflection, paraphrase and above all congruence. He/she relies on being open to what he/she hears and being prepared to take the risk to reveal to the other the impact of what is being said. The revelation involves the therapist's own frame of reference, his/her emotional and psychological state at the moment of encounter as well as the developing felt-sense of what is happening in the moment. Felt-sense, as it implies, involves the somatic reaction experienced in the encounter. The important part here is that the therapist is trying to see the experience of the other as if he/she were the client. He/she is trying to create the most precise Buber-esque "Thou/thou" encounter possible. It is not about bracketing what he/she is but using that as a comparator but not in such a way as to overwhelm what the

client is trying to say or using what is in the bracket to reinterpret the client's words and create for them or push them into forming a new-way of being.

In other words the therapist is interpreting what he/she is hearing, but reflects that back to the client, for validation "is this what you are trying to say, because here and now this is the impact you are creating; is that right for you?". He/she acknowledges that he will get it wrong, but a client will correct him/her because s/he wants, not to make a good impression, but to marshal his/her description to match their experience accurately and for their benefit. "No I am not meaning that in that way, I mean this in this way". They use this to check the sense of the words coming out of their mouths.

While the givenness of a phenomenon may begin to reveal itself in an interview, it is only ever the givenness at that moment. In a sense it emerges to the surface during the encounter, perhaps to then submerge back into a client's sub-conscious where other forces are at work and then may at some future time re-emerge in a different guise.

The key element here is the *as if* element of Rogersian thought. I can never fully comprehend the experience of an individual because she is she and I am me and even if I were to experience relapse for myself, it will be my experiencing not hers. What counts as an accurate description of an experience is only ever a simulacrum of the event. It relies on the memory, therefore, it is always selectively interpreted before it comes out of the mouth of the person. A person is always in a process of being created, so it is impossible to achieve outside third party accurate descriptions of what a person experiences (Kierkegaard). One may be permitted to view at a given time part of the process of "coming to" but that coming to is part of the existential journey of living. Here I would go so far as to even use the word surviving.

An alcoholic uses alcohol in order to survive and comes to believe that it is increasingly necessary. In recovery he or she needs to survive without it and is surprised, perhaps, to discover that they can (P6).

3rd August, 2017

There may be commonalities of experience and AA members eagerly seek them out because of the need, in my opinion, to survive and not want to ignore (deny) actuality which might be necessary for them. It may not be relevant at this point and can be set aside, but it may equally become central to their way of being later and so needs itself to be bracketed. But even this statement is only my interpretation of what has been said within the transcripts. I believe it to be accurate and not a misrepresentation of what has been said. I am being faithful to what I have heard, so this is my "as if" representation of what has been said.

The one major area of divergence I see between therapy and research is that the therapist is not looking for any wider application of what he/she has heard. What emerges in the interview applies to that participant and that participant alone. It may be that another client talks in a similar vein, but it is only applicable to that client. If one applies the one to the other, then one misses the point of "as if". I am now applying my interpretation to client B "as if" I am thinking as client A and not as me responding to client B "as if" I were client B. There can be no generalised themes which are applicable to all in the interpretation of their experiences. This is called transference.

In the case of those who perceive themselves as having a group sameness (as in AA) this process of viewing the self "as if" they are the same as others is permissible to a point, but only if the person views the "as if" as being relevant. Where not, "as if" can be set aside, but as was noted with the "little sayings" which irritated P6 they were set aside at first, because the "as if" did not work. Later he integrated them into his way of being because the "as if" made sense. Relapse teaches a person that this is not who they want to be. Sobriety is their way of finding out who they want to be and this will change. P6 needs the Steps because who he wants to be is not what he is, but the Steps he believes (because he trusts the "as if" of others) will help him achieve this. He like the others is in the process of making a self which is acceptable to him. There was a loss-of-self as potential beings because the participants immersed themselves in the day to day meaningless trivia of alcohol. It is only when they face the depths of their anxiety that they begin to see the gaping claims of who they are (functioning alcoholic) and who they want to become.

That said AA does set this aside to posit there are certain processes which have commonality; be sober, be spiritual, avoid ego. With the exception of be sober the other themes are no different for non-alcoholics; Love your neighbour as yourself.

18th September, 2017

The problem in doing a literature search before a study begins is that the mind becomes trammelled by the theories and speculations of the ATRF even before the participants are approached, so that the need for bracketing (due to the process of the search, let alone any preconceptions one may have previously had) becomes more prevalent due to the process of gathering information. It avoids contamination through bias. The benefit is that it helps discover what is "out there" and so justifies the research question. But I suspect that the cart is being put before the horse.

So far I have been looking at relapse through the eyes of the ATRF. Their means of looking at the phenomenon (in-patient treatment, observational and cross-sectional analysis) is largely based on predictors of what occasions relapse, when is it most likely to and what a person has to do to avoid it. This is all drawn up within the nebulous context of life-goal, or treatment outcome and is aligned to quality of life. The key word here is always attenuation, i.e. lessen, head off, reduce etc. rather than eradication. What is the dimension that is added in this research? It is the question of time. Inherent in the question is that the participants are in sustained recovery and that they manage their lives without relapse, so that many of the strategies they learn in treatment may be valid, but there may be another dimension to their style of recovery which differs from one who is in recovery for just one year. There is research which suggests that it takes time just to learn to be sober and for the teaching of treatment to sediment into the way-of-being of an individual. So what happens if someone is embarking on recovery but keeps relapsing? How would they view this? Are they in recovery, or is their notion of recovery flawed? They are trying to be sober but also drink and the two are incompatible.

If the desire of outcome is to be able to drink moderately, but then it is found that this is not possible, does the goal remain the same, or does the person have to embrace abstinence, whether they like it or not? Their choice in the matter goes; they have no

volition in their action; abstinence has to be imposed on them or by them because what they desire is incompatible with their method. They may not have to be coerced but they have to accept that there is some limitation upon them.

10th October, 2017

If I think of an attempt to do something and to try and set out to achieve something and maintain that change successfully day after day, how would I, or anyone else, feel if I kept being knocked back (relapse). I am assuming here that the ATRF is right when it says alcoholism is chronically relapsing and inevitable. So no matter how hard I try, no matter how much effort I put in, I have to expect (if I follow that argument) that at some time, in some way, the whole pack of cards will collapse and I will have to begin all over again. Recovery becomes nothing more than periods of respite between the inevitable return to drinking. Is that an acceptable quality-of-life? Is that an outcome goal worth fighting for? But, I hear so often that relapse-free recovery is perfectly possible, so that the ATRF is wrong when it classifies alcoholism as relapsing!

What sort of effect will that have on my resolve to continue, or will I come to a point when I say, like Alan Bennett, "Stuff that for a lark" and just give up? Is it reasonable to expect an alcoholic to be suffused with a combination of continuous motivation and expectant relapse? At what point would this be construed as failure, or a waste of time? It seems to me that we are expecting alcoholics to breed, somehow, resilience to failure, which is not demanded of other people and can literally become soul-destroying.

Appendix 15:

Reflexive essay on the research process and my current understanding of relapse

This chapter offers some reflections on my experience of the research process and shows how my, current, understanding of the phenomenon of relapse and alcoholism has been shaped by my participants' narratives. It begins with the clinical understanding of relapse and craving and then explores the wider world of a recovering alcoholic.

My initial thoughts on the process of defining relapse versus a slip/lapse

Clinically and empirically, I have subscribed to the view (as being, also, intuitively reasonable) that relapse, in the context of abstinence, was a return to consumption after an unspecified period of non-drinking, i.e. relapse was a negative, retrograde step (Edwards and Gross, 1976); consumption could be quantified as being a single beverage. If harm-reduction (Kellog, 2003) was the treatment outcome-goal, moderate drinking, i.e. socially acceptable, (Reinert and Bowen, 1968) was tolerable. This could be defined as not attracting concern (from either the drinker or his/her immediate environment or professional diagnosis) or any undue moral/social censure by either normative societal standards or even some disinterested party who might have witnessed the event.

A slip/lapse I conceptualised as being a single, discrete episode of consumption which, though problematic or construed negatively, was contained and did not escalate into further consumption. Conversely, a relapse involved unscheduled increases of drinking, over time, requiring concomitantly, greater efforts and determination to return to the original treatment plan or goal. However, P2 whilst in part, fulfilling the first criterion for a lapse, still considered a single mouthful of alcohol "*catastrophic*" (P2: 30) taking her months to overcome and the experience of which still haunted her years later; her narrative, therefore, blurred this distinction.

A further two factors delineated my concept of relapse; the continued consumption of alcohol and the length of time during which the relapse occurred, unless moderate drinking formed part of the quality-of-life determined by an individual (Tiffany et al., 2012). In this latter case, the resumption of untroubled drinking could not, properly, be construed as a relapse, because drinking was now part of the normal lifestyle pattern of socialisation with which an individual was engaged. If abstinence was the primary outcome-goal then recovery/relapse appeared to be a binary construct.

However, as I now understand, recovery/relapse is not always viewed as a binary phenomenon, but that some recovering-alcoholics believe that they exist in a perpetual state of oscillation between these states, as circumstance and time can affect their mood state, causing the salience of alcohol-use to fluctuate minute-by-minute. Successful recovery, therefore, becomes the maintenance of a gap between recovery/relapse which is mediated, not only by deploying subjective coping-strategies, but by a person's evolving orientation towards the self as an-alcoholic-in recovery-from-alcoholism and the belief that his/her life will always be better if sober. In recovery an individual can make this autonomous choice.

A third mediating factor, i.e. that which I had believed, potentially, turned a drinking episode (slip/lapse) into a problematic relapse (Robinson and Berridge, 1993) appeared to be the phenomenon of craving (Fox et al., 2007), which was not properly understood or defined by the ATRF (Becker, 2008) but which appeared, inextricably, to be linked with the concept of self-efficacy and loss-of-control (Bergmark and Oscarsson, 1987), i.e. an inability to stop drinking once it had restarted.

The cause of relapse could be attributed to a single or aggregate cluster of stressors (Breslin et al., 1995) with which a person perceived that s/he lacked the ability to cope (Moser and Annis, 1996). Relapse, in its simplest form, could be construed as an individual's use of alcohol (Cooney et al., 1997) in order to cope with negative-affect (Hall et al., 1991), under the misguided belief that s/he possessed the self-efficacy to control his/her intake (Bandura, 1977), but where any failure to do so could be addressed and, theoretically, remedied by professional therapy (Marlatt and Gordon, 1985).

What my study has informed me is that relapse, amongst those who are self-labelled alcoholics and living in sustained-recovery, is construed in ways which neither I nor the ATRF have, regularly, considered. Amongst the participants the construct of relapse, can extend to failed attempts to secure non-drinking (P3) or the moderation of drinking (P4) and, when abstinence is the proximal outcome goal, can even be a logical (though risky) form of self-testing, a phenomenon not usually evident within those undergoing treatment (Fernandez-Montalvo et al., 2007). This is determined by how an individual understands his/her subjective meaning of what it means to be alcoholic.

For example, two participants the one independently sober (P2), the other assisted by professional treatment, (P4), both of whom had, at one time, accepted the diagnostic label of "alcoholic", subsequently went on to think:

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

and:

"P4: ... I think it was it was a matter of, I think I'll test myself, see if a really am an alky..." P4: 56

In both cases, however, the question was not just whether they could drink, but whether they would, ubiquitously, succumb to the phenomenon of craving, i.e. "*want another one again*...", or as P4 put it:

"...I drank the rest of the bottle, um, 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)

Though each participant had developed idiosyncratic coping-strategies, their belief in self-efficacy to avoid craving was not determined by any particular quality inherent within the strategy, but was, however, linked to his/her existential belief in what it meant to be alcoholic. It was this belief which informed his/her understanding of craving (or loss of personal control) and, in fact, pervaded his/her sense-making process of appraising relapse in the context of sustained-recovery. Nor, was it understood, that craving had to be related to some curious phenomenon triggered by

neuronal chemical changes brought about by drinking. Craving could exist at the outer limits of obsessional thought, which could prevent a person resisting the first drink. For example, P1, who was four years sober, still believed that:

"P1: .... 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: 117-118)

The overall message of the participants' narratives seemed to indicate, to me, that being alcoholic, understanding the phenomenon of alcoholism and the processes of and rôle which relapse played within a life of sustained-recovery, was always subjective and should be treated as such. Craving, as a phenomenon within the relapse process, can serve as an example of this fact.

For P1: his evaluation of craving was linked to the idea of his not being able to exercise freewill:

"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..." (P1: 614-615)

He may have been, metaphorically, describing a phenomenon which, in biomedical terms, is expressed as a loss of inhibitory-control (Fitzgerald and Zucker, 2006) but, for him to make sense of his relapse he couched his experiences in purely moralistic terms. His recovery-way-of-being now demanded a level of moral probity, which he termed as being "*spiritually fit*" (P1: 149), which gave his abstinence-based lifestyle purpose.

For P2: although she believed that she had accepted her status as an alcoholic, drank only one mouthful of alcohol. Her somatic and mental experiences, though uninfluenced by subsequent consumption, precisely mirrored her experiences of craving when she had been drinking:

"P2: ... 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..." (P2: 52-53)

Craving, for her, was commensurate with her obsessional thoughts which lead to her self-testing her status as an alcoholic. Subsequently, her sense-making of relapse lead to her understanding a subjective construct, "*complacency*" (P2: 178), which required a need for increased vigilance to counter such obsessional thinking.

For P3: relapse was part of his quotidian attempt/failure to secure a state of sobriety. He understood craving as his compulsion to drink and his need to maintain a state of alcoholic equilibrium within his body (though not to avoid withdrawal):

"P3: ... 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..." (P3: 81-82)

His sense-making of relapse meant that he developed an existential awareness of self, rather than an understanding of relapse, *per se*, which he viewed as an iatrogenic process. Having once achieved sobriety he has never relapsed.

For P4: he began to experience a re-emergence of craving as, during relapse, he sensed that his need for alcohol was rapidly increasing and that, in a week, he would be back to drinking at his historic levels:

"P4: ... 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..." (P4: 74-76)

In the context of his relapse, craving taught him his need for restraint and, particularly, in the areas of intellectual arrogance (which he termed "ego") and his requirement for the acquisition of the dispositional quality of humility, which was the only means by which he could accept the label of "alcoholic". Thus he made the requisite changes to his life to secure sobriety.

For P5: she did not experience craving post-relapse, but her need to drink round-the-clock, meant that she was familiar with this phenomenon:

"P5... 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..." (P5: 80-81)

Consequently, craving did not form any intrinsic part of her immediate sense-making of relapse, but it did enhance her sense of vulnerability as she was now more clearly aware that alcoholism perpetually represented the "*bogeyman*" on her shoulder:

"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: 151-152)

Finally, **for P6**: for whom relapse formed part of his failed attempts to moderate his drinking (with professional help), craving was his inability to have one drink without the need for more:

"P6: ... you begin to understand what that means, it means you cannot have one drink because you will want another and another..." (P6: 253-354)

He would experience this in social situations towards the end of an evening when:

"P6: ... 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: 385-387)

His sense-making of this phenomenon, which he incorporated into his overall understanding of recovery, was used by him to reinforce his sense of puzzlement as to why he found the concept of abstinence so difficult and, therefore, question his own ability to appraise that and other situations/concepts without some perverse form of irrational thinking. He developed open-mindedness.

In short, the experiences of these participants, as they have been related within this study, lead me to believe that a clinical approach (towards the attenuation of relapse) has to discover perhaps, what existential meaning the use of alcohol (or any other empirical label) holds for an individual and seek to understand what the implications of moderation or abstinence may entail. Secondly, that whilst exploring the immediate antecedents of a relapse and developing coping-strategies may be important, account needs to be taken of how a client views the phenomena of alcohol/alcoholism and being alcoholic. Biomedical constructs, which have been empirically identified, can be usefully described (sometimes even metaphorically) by those who, subjectively,

experience them, thereby providing a more detailed picture of what they mean than could otherwise be developed in the clinic or laboratory.

More specific reflections on the phenomenon of relapse

Granted access into the private world of a recovering-alcoholic is to be invited to engage with a broadly redemptive life-narrative, but one where, whatever his/her length of sobriety, each narrative reveals that s/he believes that s/he is never free from relapse and the burden (however light) of being alcoholic:

"P5: ... I hope I haven't sort of shown, indicated, implied that, um, it's, it's hard work all the time, it's nothing, nothing like as hard work as it was when I was drinking..." (P5VT: 445-447)

Relapse (implying a failed attempt at securing cessation) and active-alcoholism appear synonymous representing a world that is troublesome. Potentially, a life of recovery is not one *from* alcoholism/relapse, but necessitates learning to live in recovery *with* alcoholism/relapse (Lakeman, 2013). Nor does it seem to matter what relapse *is* or how the clinical world might define it (Gorman, 1989). The primary concern is what happens in relapse: how each alcoholic believes s/he changes; how s/he affects those closest to him/her; and how relapse corrupts his/her personality; or how s/he views him/herself causing him/her to be demeaned in the eyes of the self and others. These things will happen because s/he is alcoholic.

Relapse involves consuming alcohol, but the process which motivates a person to drink may begin days, weeks, months, even years beforehand. It may be a conscious decision; a desire to test the veracity of the "alcoholic" label; or develop outside of their conscious awareness. But, when the act of drinking takes place it is done, in the main, with the expectancy that this time the drinking episode will not see history repeat itself. P3 was a notable exception as he relapsed knowing that the outcome would be negative "*positives will all go, as soon as I pick this up*" (P3: 75).

Sharing relapse stories, either as here within research or with fellow AA affiliates, serves as warning to the self and others. There may be both phenomenological and

experiential similarities/differences amongst these discourses, but, it is only through developing an intrinsically subjective rationale for relapse that each participant begins a process of comprehending their alcoholism from their frame-of-reference. In revealing his/her experiences each person is only speaking of or about him/herself:

"...I can't speak for any oth... other alcoholics..." (P1: 246)

Relapse drew the participants closer to AA as a place of comfort, learning and where, no matter how shameful or distressing their stories might be, they were listened to empathically and without judgement; the salience of AA should not be under-estimated, in my opinion. Their several relationships with that organisation were different, as AA fulfilled their particular needs in unique ways. For example: providing a sense of camaraderie and the opportunity to be a good Samaritan to others (P1): a place to share the warnings derived from experience (P2); a trusted forum for self-learning and improving self-awareness; (P3); a place to learn humility and pro-social values (P4); to serve as a surrogate family (P5); the only locale where people understood, non-judgementally, the phenomenon of alcoholism (P6).

Active-alcoholism, in varying degrees, had involved a life of emotional unmanageability, physical distress (caused through excessive consumption) and psychological trauma which relapse highlighted. Each person became increasingly ensnared in the viscid reticulations of a condition that was, initially, perceived as beneficial but, gradually, became self-destructive. Each was subject to the process of time, but their acquisition of alcoholism was different. Likewise, little-by-little, relapse helped transform their lives (by motivating sobriety) into ones involving emotional manageability; physiological recovery; and relative psychological well-being, but their gratitude for this life could only be, realistically, viewed as they perceived it (Rogers, 1951), i.e. the person they were then; are now; and were in the process of becoming (Rogers, 1967).

Relapse served, apparently, as a temporal fulcrum between these two worlds, yet the phenomenological questions of what constituted *alcoholism,* what it meant to be *alcoholic* and how best to describe *relapse* remained, essentially, unanswered. In fact, a life of sobriety, as they described it, appeared to indicate that such questions were unanswerable and in one case (P3) should remain so and where attempts to provide

an explanation revealed subjective differences and contradictions. Nonetheless, as these participants severally demonstrated, a life of sustained-sobriety was, mercifully, not contingent upon rational understanding or empirical explanation of relapse. In fact, a state of confusion, paradoxically, reduced the risk of relapse by enhancing their need to be "*vigilant*" (P6: 329), thereby avoiding "*complacency*" (P2: 178).

By a process of trial (sobriety) and error (relapse), each came to accept that alcoholism was "... *cunning, baffling, powerful!"* (AA, 1976: 58-59). In that sense, relapse was beyond comprehension, so that each aimed to find a unique way-of-living (based on AA's teachings) which permitted him/her to manage the condition on a quotidian basis. Relapse was not merely a "learning experience"; its pedagogical rôle taught them that recovery must be abstinence-based.

Participants were not averse to describing those dubious character traits which they felt they exhibited in relapse (but which, in recovery, they sought to curtail), by using the same stigmatising language by which society distinguishes the characteristics of *all* alcoholics: e.g. weak-willed (Angermeyer and Matschinger, 1996), morally defective (Schnittker, 2008), self-destructive (Crisp et al., 2000, 2005) dangerous (Link et al., 1999) deviant (Phelan, 2005), incurable (Bischof et al., 2005). If their families, as potential examples of wider society, had abandoned any hope of them getting well, in relapsing they arrived at a point which constituted a personal nadir of despair. The study indicated that families are not, necessarily, a source of inter-personal support for recovery. Yet from these ashes a phoenix of hope could arise.

Their relapse-narratives not only ennobled their individual battles to secure and maintain an on-going state of sobriety, but also indicated that their struggle, though achievable, was fraught with opportunities for recidivism. Recovery was "*fragile*" (P1: 496) and the fear of relapse necessitated a quotidian process of recommitment to the goal of sobriety/abstinence. Relapse opportunities comprised both external triggers (which, for some, necessitated an avoidance of all contact with alcohol or situations or locations where alcohol was present) and a misguided, internal belief of self-mastery for which relapse became, perhaps, a test of self-efficacy.

Integrating relapse into their recovery-lifestyles appeared to be less a matter of understanding what happened to cause them to drink again and more of their need to

explore and understand, *phenomenologically,* what it meant for them to be an alcoholic (both actively and in recovery) and, importantly, when affiliated with AA. The clinical search for causality may not be as relevant as clinicians believe.

Each was affected by the passage of time within their lifespan, so that it could be held that the times before, during and after relapse were discrete phenomena within that temporal process. This much had been concluded by Takeda et al., (2013) as the outcome of their phenomenological study. But the findings of my study, suggested that it was the diversity of experiencing within that temporality which aided the way in which a person expressed his/her relapse.

Whatever the reason for relapse, it acquired potential meaning or, as P1 (P1: 222) stated, it could be "*legitimised*", but *only* in the light of sustained-recovery. Without a subsequent recovery, i.e. a sustainable period of sobriety, post relapse, it was simply a return to active-alcoholism, of uncertain outcome, but which could be fatal. Any meaning of their present situation was made in relation to their past life of active-drinking.

There appeared a subtle distinction between expressing relapse (in terms of causality) and the potential meaning of relapse (i.e. its personal significance). Amongst these participants, there may have been an overall suggestion of what it meant to be alcoholic compared with the descriptions of the phenomenon provide within AA literature and the stories of fellow AA members. But the litmus test was always, how comparable could these experiences be to them, *as individuals*, when compared with what had happened in their past and in their present? It was their frame-of-reference which determined any meaning-making.

As a safeguard, the participants detailed a variety of personal coping-strategies, differing from person-to-person, but this formed only a small part of their defensive *armamentarium*. Relapse was to be avoided not simply because they acknowledged that specific triggers precipitated obsessional thoughts about drinking, but because the act of consuming alcohol was now antithetical to their way-of-life, as *recovering-alcoholics*. What caused this gradual transformation was intrinsically personal, but hard for them to decipher. Triggers may have, historically, served as an *excuse* to drink but, in retrospect, no longer furnished any cogent *reasons* for drinking. This was

variously expressed as an absence of choice (P1, P6); an act of impulse (P2, P5); being subject to a "*mysterious force*" (P3:26); or even an intentional act (P5).

The existential meaning of being a *recovering-alcoholic*, as a way-of-life, was uniquely construed by each individual, where relapse threatened to unleash a return to another way-of-being (a variously described *effect*, sought by one whose mindset had returned to that of being an active-alcoholic). In other words, relapse could be described as taking a drink in the mind, a process of planning, (sometimes out of awareness) which emerged long before the act of physical consumption. As a process, thoughts of relapse, perhaps, edged them closer to a tipping point from which there was no return.

It was not only that they could not control a metaphorical Mr. Hyde, (after all, each participant had relapsed) but that Hyde represented something which had, powerfully, tapped into a way-of-being which provided them with: relief (P1); or pleasure (P6); and, in some cases, liberated fun (P5). In their individual ways, being alcoholic had, at one time, served a useful purpose. P3 poignantly and metaphorically described relapse as "*an old friend returning*" (P3: 35). Recovery, gradually, became their substitute for active-alcoholism, so that relapse would not now be potentiated by triggers, but by the personal belief that their lives would be better drinking, than not.

Their drinking/relapse had demeaned them primarily in their own eyes and, concomitantly, in the eyes of others. They may have convinced themselves that drinking was beneficial, but what relapse had awakened within them was a feral side to their nature. In contrast, I was struck by the sensitive and moral tone of their narratives and the way in which each focused on aspects of moral and ethical behaviour, e.g. "*honesty*" (P2: 343) or "*humility*" (P4: 327) which they held as being necessary for their several recoveries in becoming good, social citizens. The value they placed on abstinence (and with it an implied way-of-life) became apparent to them, not simply through the writings of AA (1976) but from the stories of other AA affiliates. Without abstinence they came, over time, to believe that they could never find peace of mind or achieve any meaningful kind of social integration, primarily with their families, whom they had most directly affected.

They revealed another world in which they had lived, wherein the acquisition of alcoholism lay. It was here that the salience of alcohol originally grew in response to a

lack of emotional and psychological comfort which, in time, they found that only alcohol could fulfil. They variously described an imperceptible movement from relief to habitual and isolated consumption beset with problems, which they were, doggedly, determined to overcome. In retrospect it was a world sometimes of puzzlement, as to become alcoholic was never an intentional act.

Relapse provoked a rapid return to the world of active-alcoholism which was viscerally painful. It triggered critical physical symptoms; hallucinations; anxiety; hysteria; self-loathing; it unsettled families; destroyed the basis of trust; and entailed a seemingly endless list of misery and wretchedness. Immediately prior to and during the initial stages of relapse, rational belief appeared to be suspended, in a false hope that this time, the outcome would combine all that was good surrounding drinking, without any of its concomitant negative outcomes. But this quickly changed as, for some, remorse and self-recrimination came flooding back.

But their world of recovery is fragile. Much time in recovery was expended in understanding the nature of alcoholism or revising their past to accommodate the fact that much of their errant behaviour and bafflement was caused by their becoming alcoholic. There existed a tangible inner subjective-world to which, at times, they withdrew for support and guidance (Kelly and Yeterian, 2011); they called this AA. This reflected that, for whatever reason, participants living within a non-alcoholic-world, which at times seemed less than welcoming, came to realise who they were or at least were made aware of how society perceived them, which occasioned feelings of difference, but more worryingly, stigma, (Crisp et al., 2000). These were overcome by positive social processes through their identification with and internalisation (or acceptance) of AA's alcoholic recovery-world (Room, et al., 2005).

AA possesses an ideology, which may require years to comprehend, but its sense of fellowship, as the milieu in which they could be heard and valued, could be more rapidly experienced and understood. AA, as a meeting place for those attempting recovery, was also a locale which provided a poignant reminder of the terminal price many would pay through relapse. 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.

What, potentially, brought them to this place; ensured their loyalty; and motivated them to follow this chosen pathway, one-day-at-a-time, may differ between each member. But, within AA, the individual experiences of its members have validity and are to be listened to because, however much their narratives vary, they believed that theirs is the Bunyanesque story of Everyman. There was no one way to become an alcoholic; no single means of experiencing relapse; no definitive mode of securing sobriety; no absolute definition of recovery nor description of a quality-of-life developed through being sober. The only constant axiom, applicable to all and from which there appeared to be no deviation, was their need to be physically sober, each and every day.

Their world of recovery was also a world of being different. Though they discerned their meaning of relapse in their own time and in their own fashion, they did so in the context of AA. AA (1976) informed them that they were suffering from an illness, not perhaps in any overt medicalised sense, which, as a defining label, did not appear, within this study, to have any particular import or commonality of definition. But, AA's teachings were also overlaid with moralistic signposts (the need for a personal moral inventory; reparation for past anti-social behaviour; the willingness to help other alcoholics; etc.,) indicating a need for a conscious change of attitude and outlook as a free-agent, who was consequently culpable for past, present and future thoughts and behaviours (Frankfurt, 1971; Dalrymple, 2006).

Participants selected particular moral qualities (e.g. honesty, humility, altruism, discipline and consistency) which they deemed as specific to themselves and made the pursuit of such virtues one of the motivational bases for their change of self. This choice appeared to be determined by their perceptions of personal deficiency. For example: for P1, the vice of solipsism was transformed into the virtue of altruism; P2 identified her need for honesty; P3's rigid mindset about his identity became a desire to develop self-awareness; P4 combated his arrogance or need to be "*driving the bus*" (P4: 258), by learning humility; P5 turned her anger towards her sister into gratitude; whereas P6 transformed intellectual denial into open-mindedness.

Yet, while the nexus between a (psychiatric) medical condition being, simultaneously, a cause for assigning blame or moral deviance is an unscientific oxymoron, AA and its

affiliates wrestled with these two opposing views in a tight juxtaposition, without resolving the debate. In varying degrees, I sensed the participants shared this epistemology by viewing themselves, post relapse, as living within society and yet being different from non-alcoholics. Despite the outward physical appearance of normality, they viewed themselves as being part of an ethnographically separate group who self-labelled as being *alcoholic*. This ontological view of self, as being *different*, was openly asserted by P6 when he averred:

"P6 ... I am an alcoholic, and I am not saying that lightly, that, that is a recognition that I am different now...

R: Yeah.

P6: ... I don't know that I was always different but I am now and now that I, I, you know, have gone through, um, active alcoholism and got to this point (clears throat) and, um, it gives me a way of dealing, er, with things, it seeps into you, that's the truth of the matter and, er, makes it more difficult, makes it difficult to hold and do things which you know are bad and are likely to cause relapse." (P6VT: 170-177)

For others it was, perhaps, implied by their acknowledgement (to themselves) that they must avoid situations or emotional states where alcohol could re-exert its malign influence upon them. The ATRF (and society at large) may provide a generalist paradigm for the phenomenon of alcoholism and relapse, but it was their physical bodies, their thoughts about alcohol and the somatic effects it had upon them, once consumed, which provided the single most exemplary unit for determining and understanding this sense of otherness and what it meant to be alcoholic.

Even in recovery, they inhabited a world of confusion, yet they seemed to find some clarity within AA which, again, they all approached in differing ways. One person's understanding of relapse diverged from another. Being "in recovery" may imply the notion that it is a life-long process of learning from the lessons of the past, but it was variously expressed as a "*gift*" (P1: 675); a "*cleansing*" (P2: 343); "*a journey*" (P3: 454) and even, by an avowed atheist, a "*miracle*" (P6: 195), because the experience of their recovery differed for each person.

Was the reason that these participants had not died as a result of relapse merely a matter of serendipity ("...*some die, some get into dire trouble. I was lucky, I didn't*... P4: 396)? P3, for example, drew on metaphors of gambling, risk and chance, e.g. "*dodged the bullet*" (P3: 390); "*Russian roulette*" (P3: 396); and "*playing the odds*" (P3: 403) to describe the type of behaviour which characterised the relapse of some people, but which, conversely, helped him to stay sober:

"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)

Unwittingly, P3 described the self-same attitude of mind whereby another participant, P2, had entertained the belief that she could relapse whilst emerging unscathed or devoid of any future consequences:

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

Relapse, potentially, becomes a gamble, but these alcoholics lacked prescience. In recovery and unable to foretell the future, they could not always devise fail-safe coping-strategies because the future was unknown and unknowable. But their lives of sustained-recovery were not contingent upon such understanding. It was quite possible to lead a sober life, whilst developing personal awareness by listening to the varying life-stories of other alcoholics who relapsed and comparing them with their own. The key here was the variety of experience, as P1 said, each person's story was a "*reflection*" (P1: 654) of another, but was not the same and P6 could stress not only his personal sense of difference, but the difference between alcoholics:

"P6: ... you're different people and you're bound to have different experiences, because you're in different environments, er, for a start, but, er, you know, but not everything has to be the same to be the same problem." (P6VT: 66-68)

Consequently, relapse taught each to develop an appreciation of what life was like to be alcoholic in their own fashion and the multifarious ways by which it was possible for them to construe alcoholism and relapse and the steps they needed to take, in order to keep themselves safe. If there was one thing which did unite all the participants, it

was the belief that they must deny to themselves any use of alcohol. How they did this and their reasons for doing so, however, was their own, unique achievement.

In their several ways each participant, though now in recovery, continued to carry the burden of relapse (and alcoholism). But the burden was made lighter, I felt, as each had formed an opinion, for which relapse was the catalyst, as to their personal understanding and expression of what it meant to be alcoholic. With this came specific and idiosyncratic coping-strategies which, they hoped, were uniquely suited to their circumstances, but where abstinence was always the primary safeguard. In time, each formed and continued to re-form a quality-of-life which made life manageable and pleasurable. Relapse taught that without sobriety none of this would be achievable:

"R: ... But what I tend to notice is that (coughs) people who have relapsed and are now in recovery, everybody interprets their relapse and their unique experiencing of relapse in a in a unique and different way...

P3: Yes.

R: ... even though there is a kind of overall agreement about what alcoholism and relapse might be?

P3: The process is the same or very similar but the actual feelings for the individual can be completely different.

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: 26-26)*

Clinical Implications

Examining the immediate antecedents of the drinking-event, relapse-prevention treatment identifies potential triggers; devises coping-strategies to manage relapse or prevent its occurrence (Marlatt and Donovan, 2005), thereby aiming to strengthen a person's self-efficacy and improve his/her self-esteem (Marlatt and Gordon, 1985).

Though it was not the aim of this study to make definitive pronouncements regarding clinical interventions, the RPM model can be compared with the *processes* followed by this study's participants and some differences noted. (A tentative model of the recovery process, post relapse, was provided in Chapter 12).

First, the antecedents leading to relapse may occur over months and years rather than days or weeks and so are difficult to determine; this is *contra* to the RPM. For example: P5 relapsed after "*two years*" (P5: 8); P2 relapsed after seven months, during which time she believed that she was doing "*all of the right things*" (P2: 8) to keep herself sober. Participants did not focus on immediate antecedents, which may not always give a clear picture of what precipitated relapse preferring, instead, to view it as indicative of their life-long association with alcohol.

Secondly, unlike the RPM, they were not always capable of identifying potential triggers for a variety of reasons. For example: P3 stated "*I don't know what I would class as a risky situation*" (P3: 346); P6 believed that his state of "*denial*" (P6: 132) prevented him from perceiving risk; and P4, even though he was aware of risk, consciously chose to drink "*my plan was I'd have a drink that day*" (P4: 198).

Instead, to combat risk, they employed avoidant-strategies which, primarily, reduced their proximity to alcohol ("*sit the far away from the restaurant on the train as possible*" P5: 138); removing alcohol from their immediate environment ("*I didn't have booze in the house*" P2: 10-11) and associated paraphernalia ("*changed the glasses*" P4: 149); even eliminating it from food "*avoid alcohol even in cooking*" (P6VT: 252). A continued attendance at AA also served as a "*defence to to having the first drink*" (P6: 299-300). Hence, the rôle of self-efficacy, the goal of most cognitive and behavioural modalities (Castonguay and Beutler, 2006) and the RPM, appeared to be held with deep suspicion by participants, being reminiscent of the exercise of willpower which had previously failed them:

"*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... using willpower to stop, didn't work...*" (P6: 201-203)

Their narratives were replete with examples of self-efficacy or determination, "*fighting*" or "*battling to try and prevent this relapse happening*" (P3: 17) which ended in relapse:

"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)

Instead, they accepted the idea of an addictive-self by adopting the label of *alcoholic*, not in any pejorative sense, but which indicated that in this one area of functioning, in certain circumstances, they lacked the self-efficacy to resist alcohol:

"P1: ... 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: 117-118)

This, paradoxically, increased their self-esteem as it permitted an honest, critical appraisal and acceptance of how they viewed themselves which, heretofore, they were incapable:

"P6: ... once that obsession had gone and I realised I didn't have to drink every day that was a huge weight lifted from me." (P6: 213-214)

Being unburdened by an incongruent self-image, the admission of being alcoholic meant that they could now address their need for abstinence. This was not the same as being sober or not drinking. P5 was sober for two years and P2, for seven months before they relapsed. P4 relapsed and remained sober for a further 14 months whilst attending AA ("*I'd been in AA 18 months and and I'd been sober then for 14*" (P4: 280), but none had yet achieved a lifestyle that was abstinence-based. They acquired a level of functioning which was acceptable to them, only when they engaged, more fully, with the philosophy of personal change which AA offered:

"P4: ... it was only when I, I actually sat down and, um, said to somebody, "Look I, I, I need to do this, um, this 12 step programme, um, I can't do it on my own

R: Right.

P4: ..."will you help me?" " (P4: 302-305)

For sustained-recovery to be achieved, a more holistic understanding of relapse may be required than is currently envisaged within prevention-treatment. The relapse event is not, perhaps, to be regarded in isolation, but better contextualised into an appreciation of what it means for an individual to be alcoholic and how s/he chooses to live a recovery-lifestyle.

However, it is, perhaps, too jejune to describe or reify the changes which take place within a person, during the recovery process, as simply *identity change* (e.g. Kellog, 1993; Khantzian, 1994) which therapy helps transform. As P6 notes;

"P6: … I am still the person I was, um, er, but, but because I don't drink I'm massively different at the same time..... who knows why I drank heavily…. I don't know why that is....

R: And you don't need to know?

P6: No." (P6VT: 218-225)

Instead, there is a gradual coming to believe that the image they held of who they were, particularly in relation to their alcohol consumption and the attendant thoughts/behaviours surrounding it was incongruent ("*... because the fug of alcohol has gone you can actually look back on things, er, more clearly...*" (P6VT: 217-218). Nor was a choice between abstinence/moderation an immediate and obvious outcome goal. Relapse for some (e.g. P2, P4, P5) was a deliberate self-testing of their need to stop drinking which only relapse or the RPM's abstinence violation effect, could verify.

What follows from these clinical differences or, worded differently, what do the findings of this thesis imply? *In fine*, I suggest that there are three important implications. First, though not directly exploring either the chronicity of alcoholism (which appears implicit in the participants' view of recovery being a lifelong journey) or whether it is best construed as an illness (which, in a strictly medicalised sense may or may not have been recognised by them), this study suggests that the construct of

alcoholism being a "chronic *relapsing* illness" is to over generalise the condition's outcome. In the early days of treatment this may appear to be the case (Gossop, 2008) but, given time and acknowledging that the threat of recidivism never completely disappears, for some, the act of relapse (or compulsion to drink) can and does. It would be informative to explore and compare perceptions towards relapse with recovering-alcoholics enjoying longer, sustained-recovery (i.e. 5-10, 10-15 years and longer).

Secondly, the assistance of mutual-help groups in support of relapse avoidance is, for some people, hugely beneficial and AA is, perhaps, not the prescriptive discipline which demands a blind and unquestioning uniformity of its members which some, within the ATRF, might believe. Instead, AA prizes individual, diverse experiences of alcoholism as providing a deeper insight into the phenomenon of alcoholism and what it, subjectively, means to be alcoholic. The study of AA and its practices is profitable, I feel, both in its support of on-going therapeutic interventions and long after professional help has ceased to be immediately relevant/necessary.

Thirdly, before (or contemporaneously) with an attempt to address relapse attenuation, rather than construe relapse in purely negative terms, it is, perhaps, worthwhile to afford time (which may be months and years rather than days and weeks) for alcoholics (moving towards recovery and where, therefore, alcohol plays no part) to reflect on the existential properties of what, phenomenologically, its means for them, as individuals, to be alcoholic and what rôle they choose to ascribe to the phenomenon of relapse. For these participants, relapse served as a painful, though cathartic, experience within a process of critical self-appraisal which, materially, assisted them in reforming a congruent view of self.

Viewing themselves as different from social drinkers and as both alcoholics and as alcoholics-in-recovery, able to accept a limitation in this particular area of efficacy, significantly reduced the obsession/compulsion to drink whilst, simultaneously, increasing their sense of self-esteem and personal empowerment. As autonomous agents, relapse is not mandated by alcoholism but becomes an act of freewill.