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Exploring identity:

Living with, and moving beyond, a problematic relationship with alcohol

by

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Thesis for the degree of Doctor of Philosophy

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Dedication

For my father,

Paul Michael Chambers

1962 – 2014

UNIVERSITY OF SOUTHAMPTON

<u>ABSTRACT</u>

FACULTY OF MEDICINE

Clinical and Experimental Sciences

<u>Thesis for the degree of Doctor of Philosophy</u>

EXPLORING IDENTITY: LIVING WITH, AND MOVING BEYOND, A PROBLEMATIC

RELATIONSHIP WITH ALCOHOL

Sophia Elaine Chambers

Most individuals with alcohol use disorders (AUD) never seek or receive specialist treatment. However, much of what is known about addiction and recovery is based on pre- and post-intervention studies with patients in specialist treatment settings who tend to have severe dependence. These studies often fail to capture the complex and circuitous nature of recovery, and findings might not be generalisable to most people with AUD. The work described within this thesis therefore aimed to: 1) gain an in-depth understanding of how those with a range of drinking patterns and treatment experiences, whose narratives are largely absent in the literature, conceptualise their relationship with alcohol, and 2) generate theory about processes and determinants of recovery.

A mixed-methods constructivist grounded theory approach, comprising two separate but related studies, was employed. Study 1 involved in-depth telephone interviews with 31 members and browsers of a previously unresearched online mutual aid group (*Soberistas.com*) which resulted in the development of a theoretical framework of recovery entitled: *'managing multiple facets of self'*. This analysis highlighted important personal and social identity processes that appeared to underpin change. To advance the framework, a further two-phased study with a more heterogeneous population was conducted. During the first phase, an observational follow-up cohort study recruited 141 patients with AUD during their unscheduled attendance at a general hospital, and gained quantitative estimates of alcohol use, and related measures such as psychological dependence and readiness to change. Participants were re-interviewed six months later, and variables examined for change (or lack thereof). The second phase employed face-to-face in-depth qualitative interviews with a sub-sample of the hospital cohort, purposively selected to be a maximum variation sample using quantitative data collected previously.

Quantitative and qualitative data were synthesised to develop the final theoretical framework, *'alcohol and recovery self-concept fluidity'*, which illustrates the dynamic, fluid, and complex nature of living with, and moving beyond, a problematic relationship with alcohol. The theory posits that conceptualisations of problematic alcohol use and recovery are diverse and subject to constant (re)negotiation; individuals navigate numerous, and at times conflicting, explanatory frameworks, in order to make sense of their experiences and align themselves to an approach most suited to their needs at the time. This thesis contributes new understanding of how problematic alcohol use and recovery can be conceptualised, addressed, and researched, by gaining the perspectives of individuals whose voices are largely absent in the literature.

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Published articles (p.307)

Sinclair, J.M.A., **Chambers, S.E.** and Manson, C.C., (2016). Internet support for dealing with problematic alcohol use: a survey of the Soberistas online community. *Alcohol and Alcoholism*, 52(2), 220-226.

Chambers, S.E., Canvin, K., Baldwin, D.S., and Sinclair, J.M.A. (2017). Identity in recovery from problematic alcohol use: a qualitative study of online mutual aid. *Drug and Alcohol Dependence*, 174, 17-22.

Academic Thesis: Declaration of Authorship

I, SOPHIA ELAINE CHAMBERS declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Exploring identity: Living with, and moving beyond, a problematic relationship with alcohol

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been published as:

Chambers, S.E., Baldwin, D.S., Lo, R., Williams, S., and Sinclair, J.M.A. (2017). Hospital attendance and admission as an opportunity to engage patients with alcohol use disorders. *Journal of Psychopharmacology*, 31. Abstract Supplement: A128.

Chambers, S.E., Canvin, K., Baldwin, D.S., and Sinclair, J.M.A. (2017). Identity in recovery from problematic alcohol use: a qualitative study of online mutual aid. *Drug and Alcohol Dependence*, 174, 17-22.

Sinclair, J.M.A., **Chambers, S.E.** and Manson, C.C., (2016). Internet support for dealing with problematic alcohol use: a survey of the Soberistas online community. *Alcohol and Alcoholism*, 52(2), 220-226.

Academic Thesis: Declaration of Authorship

8. Parts of this work have been disseminated in poster and/or oral format as:

Chambers, S.E., Baldwin, D.S., and Sinclair, J.M.A. (2018). The impact of attending hospital for patients with alcohol use disorders. Presented (oral) at the Wessex Academic Health Science Network Reducing Harm from Alcohol Conference, Southampton, UK, 1 February 2018.

Chambers, S.E., Baldwin, D.S., and Sinclair, J.M.A. (2017). Ostriches and camels: understanding nuances in recovery journeys. Presented (oral) at The Society for the Study of Addiction Annual PhD Symposium, Newcastle, UK, 9 November 2017.

Chambers, S.E., Baldwin, D.S., and Sinclair, J.M.A. (2017). Understanding the characteristics and drinking profile of patients with alcohol use disorders who present at hospital. Presented (poster) at the Lisbon Addictions Conference, Lisbon, Portugal, 24-26 October 2017.

Chambers, S.E., Canvin, K., Baldwin, D.S., Manson, C., and Sinclair, J.M.A. (2017). Online mutual aid for problematic alcohol use: A study of the '*Soberistas*' peer support network. Presented (oral) at The British Psychological Society Annual Conference, Brighton, UK, 4 May 2017.

Chambers, S.E. (2016). A presentation on the '*Soberistas'* research studies conducted at the University of Southampton. Live 'webinar' with Lucy Rocca on Soberistas.com. 12 December 2016.

Chambers, S.E., Canvin, K., Baldwin, D.S., and Sinclair, J.M.A. (2016). Online mutual aid for problematic alcohol use: A qualitative study of the '*Soberistas'* peer support network. Presented (poster) at British Psychological Society Faculty of Addictions Annual Conference, Birmingham, UK, 25 November 2016.

Chambers, S.E., Canvin, K., Baldwin, D.S., Manson, C., and Sinclair, J.M.A. (2016). How does engagement with online mutual aid support recovery from problematic alcohol use? Presented (oral) at Society for the Study of Addiction Annual Conference, York, UK, 10-11 November 2016.

Chambers, S.E., Canvin, K., Baldwin, D.S., Manson, C., and Sinclair, J.M.A. (2016). '*Soberistas'*: Understanding a new form of mutual aid. Presented (oral) at Alcohol Research UK Early Career Symposium, Birmingham, UK, 15 March 2016.

Chambers, S.E., Canvin, K., Baldwin, D.S., Manson, C., and Sinclair, J.M.A. (2016). '*Soberistas*'. Presented (oral) at the Wessex Academic Health Science Network Getting to Grips with Alcohol Conference, Southampton, UK, 27 January 2016.

Signed: ....

Date: ....

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xx

Abbreviations

AA	Alcoholics Anonymous
ACT	Alcohol Care Team
AUD	Alcohol use disorder(s)
AUDIT	The Alcohol Use Disorder Identification Test
AUDIT-C	The Alcohol Use Disorder Identification Test consumption questions
AWS	Alcohol withdrawal syndrome
BMI	Brief motivational interviewing
CI	Confidence interval
CSC	Clinically significant and reliable change
DD	Drinking day(s)
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	Emergency department
GP	General practice
HADS	Hospital Anxiety and Depression Scale
HDD	Heavy drinking day(s)
HRA	Health Research Authority
IBA	Identification and brief advice
ICD	International Classification of Diseases
IPA	Interpretative Phenomenological Analysis
IQR	Interquartile range
IRAS	Integrated Research Application System
LEP	Lay expert panel
LDQ	Leeds Dependence Questionnaire
MMR	Mixed-methods research
MM-GT	Mixed-methods grounded theory
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence

Abbreviations

PDM	Pathways disclosure model
PHE	Public Health England
PRIME	Plans – Responses- Impulses – Motives – Evaluations (Theory)
PRISM	Pictorial Representation of Illness and Self Measure
REC	Research Ethics Committee
R&D	Research and development
SCT	Self-categorisation theory
SD	Standard deviation
SDiff	Standard error of the difference between scores
SE	Standard error
SIMOR	Social identity model of recovery
SIMCM	Social identity model of cessation maintenance
SIS	Self-illness separation (in relation to the PRISM)
SIT	Social identity theory
SGH	Southampton General Hospital
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
SPSS	Statistical Package for the Social Sciences
TLFB	Timeline follow-back
TTM	Transtheoretical model (of behaviour change)
UHS	University Hospital Southampton NHS Foundation Trust
VAST	Vulnerable Adult Support Team
WARC	Wessex Alcohol Research Collaborative
WAHSN	Wessex Academic Health Science Network

Structure of thesis

Chapter 1 provides an introductory orientation to current thinking, and clinical and theoretical approaches within the alcohol field. I explain and justify the literature review within the context of research guided by constructivist grounded theory principles.

Chapter 2 describes the overall research approach taken in this thesis, specifically the use of mixed-methods, with consideration given to relevant philosophical paradigms. I introduce grounded theory as the methodology selected to direct all stages of my research and explain how the studies within this thesis form a coherent body of work.

While methods/procedures specific to each study can be found in later chapters, **Chapter 3** provides a detailed account of the steps taken to collect and analyse data in accordance with constructivist grounded theory principles. The strategies outlined in this chapter apply to all aspects of my PhD study (e.g. the constant comparative method, purposive sampling, memo-writing), and are therefore included ahead of the following sections.

SECTION 1: a qualitative study of a new form of online mutual aid

Chapter 4 describes the specific methods employed for the first empirical study – a qualitative investigation of *Soberistas*, an online mutual aid group for individuals concerned about their relationship with alcohol. The theoretical framework, (*'managing multiple facets of* self'), generated through analysis of interview data, is also presented. It contains three main concepts: 'maintaining "normal" selves'; 'addressing the "alcohol identity"'; creating an "authentic self"'. Results presented in this chapter reflect the decision to focus on identity processes and their relevance to recovery from problematic alcohol use. The associated papers, published in *Alcohol and Alcoholism* and *Drug and Alcohol Dependence*, are included as Accompanying Documents.

SECTION 2: a mixed-methods observational cohort study of patients with alcohol use disorders attending hospital

In **Chapter 5**, the specific methods for the second empirical study of this thesis are outlined. This study comprised two phases: 1) a quantitative six-month follow-up hospital study, and 2) a qualitative in-depth interview study with a subsample of participants recruited during Phase I.

Chapter 6 presents the quantitative findings from the hospital study, which contextualise the qualitative narratives that follow. Descriptive statistics, repeated measures tests, and regression analyses explore the characteristics and drinking profile of the cohort, and assess change in the following six months.

Structure of thesis

Chapter 7 introduces the theoretical framework (*'negotiating alcohol use and self'*), developed through analysis of participants' qualitative accounts. The chapter also presents the findings of the first theoretical concept within this framework which explain how and why an 'alcohol-related identity' might develop.

Chapter 8 presents the second theoretical concept within the framework which explores the impact of an unscheduled hospital attendance/admission on conceptualisations of alcohol use and self.

Chapter 9 presents the third and final theoretical concept within the framework which concerns participants' experiences and perceptions of recovery.

Chapter 10 provides a summary of the main findings from the studies described within the thesis and explores how they address the overarching research aims. A final theoretical model is presented which synthesises the various arms of data described in earlier chapters. The general strengths and limitations of the research are discussed, after which suggestions for future research and clinical practice are made.

Chapter 1 AN 'ORIENTATING' LITERATURE REVIEW

1.1 Introduction

A defining feature of the grounded theory method is delaying an extensive literature review until the researcher has collected and analysed some raw data to avoid narrowing the lens through which analysis takes place (Charmaz, 2014). Literature is considered a *source of data* that must be drawn upon throughout every stage of the analysis (including write-up), and new literature will be sourced as theoretical questions arise. The literature review is therefore an iterative process and is updated as the research progresses. As such, the following sections reflect the inherently "messy" process that is grounded theory (Munhall, 2012, p.238), and at this stage, serve as a broad introduction to studies presented within this thesis.

I start by providing an overview of the burden of alcohol in the UK, current approaches to diagnosis, and briefly discuss the role of treatment. I make the case for broad inclusion criteria in research studies to capture a range of drinking experiences, and then introduce the topic of 'recovery'. I conclude with an introduction to what became a central concern of this thesis – namely, the role of identity processes in addiction and recovery. This preliminary scoping review is intended as a helpful "orientating process" to contextualise the proposed research and explore current thinking in the field (Urquhart, 2007, p.351). Literature more directly relevant to each study is woven into subsequent chapters and resembles the way in which my use of literature evolved throughout the PhD. The use of first person throughout, reflects my active role throughout the whole research process and is in keeping with a constructivist grounded theory approach (Charmaz, 2014).

1.2 Background

1.2.1 Alcohol consumption

Alcohol consumption is the third leading risk factor for disease globally, with almost 6% of deaths attributable to alcohol each year (World Health Organisation, 2010; 2014). Problematic alcohol use has serious personal, social, and economic ramifications (Connor, Haber and Hall, 2016; World Health Organization, 2014) and is increasingly recognised as major public health concern in the United Kingdom, UK (Department of Health, 2016; Pryce *et al.*, 2017). A recent review published by Public Health England (PHE, 2016) reports that the sales of alcohol in England and Wales have increased by 42% since 1980, driven in part by reduced cost of purchase, and increased

consumption by women. The report also comments on shift in drinking location, with most alcohol now being consumed at home.

Alcohol consumption is causally associated with 60 different diseases, and most commonly contributes to premature death through acute injury, alcoholic liver disease, cancers, heart disease, and gastrointestinal disease (Connor, Haber and Hall, 2016; Roerecke and Rehm, 2014). Moreover, in a recent cohort study of 19,002 men and women in alcohol treatment, a diagnosis of alcohol dependence was shown to predict significantly higher risk of less well-established alcohol-related diseases such as psoriasis, dementia, and breast cancer in men, relative to the general population (Holst *et al.*, 2017). These health problems, often combined with other physical and psychiatric comorbidities, lead to complex difficulties and increased use of secondary care services (PHE, 2016). Alcohol harms are estimated to cost the National Health Service (NHS) around £3.5 billion every year, 78% of which derives from hospital-based care (Health and Social Care Information Centre, 2015; NHS Confederation and Royal College of Physicians, 2010) – and the number of alcohol-related hospital admissions in England is rising; in 2016/17 there were 337,000 estimated hospital admissions where alcohol was the primary cause (narrow measure), 17% higher than 2006/07: however, when considering admissions in which alcohol was the primary *or* secondary cause (broad measure), the figure rises to >1.1 million in 2016/17 (PHE, 2018a).

1.2.2 When alcohol consumption becomes problematic

There is considerable variation in definitions and the terminology used to describe 'problematic' or 'unhealthy' drinking. The discrepancies may stem from contradictions in diagnostic classification systems (Saunders, Peacock and Degenhardt, 2018), a lack of consensus among the scientific community on a single theory of addiction (West, 2006), and/or public perceptions about the nature of problem drinking (Khadjesari *et al.*, 2018). As this thesis emphasises subjective interpretation of 'problematic alcohol use', I use participants' own terms in each study and appreciate that their definitions may have varied from mine or each other's, but first give a brief overview of common conceptualisations and approaches to diagnosis that served as the foundation for this work.

In public health and epidemiology, weekly unit[1] intake and patterns of consumption are often used to inform drinking risk levels as they are considered important determinants of alcohol-related harm (National Institute for Health and Care Excellence, 2010; Saunders, Peacock and

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[1] In the UK, 1 unit equates to 8 grams of alcohol (10 mL of pure ethanol).

Degenhardt, 2018). 'Lower risk drinking', defined according to the UK Chief Medical Officer's most recent published guidelines on alcohol, advises men and women to drink no more than 14 UK units of alcohol per week, spread over three or more days (Department of Health, 2016). 'Increasing risk drinking', which includes 'binge drinking' patterns, is defined as consumption between 15-50 units per week for men (or ≥8 units on a single occasion), and 15-35 units per week for women (or ≥6 units on a single occasion). 'Higher risk drinking' is defined as >50 units per week for men and >35 units per week for women according to current NHS guidelines (National Institute for Health and Care Excellence, 2010).

The latest editions of the two main disease classification systems, the *International Classification of Diseases* (ICD-11, due to be published later in 2018) (World Health Organisation, 2017) and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, American Psychiatric Association, 2013), refer to a spectrum of hazardous, harmful, and dependent drinking patterns, broadly classified as 'alcohol use disorders' (AUD); they do not specify a minimum level of consumption. While ICD-11 retains two distinct categories of AUD ('Harmful Alcohol Use' and 'Alcohol Dependence'), DSM-5 represented a shift in conceptualisation from this dichotomised classification, to a spectrum approach along a continuum of severity. Table 1 presents the 11 symptoms of AUD listed in the DMS-5; the presence of 2-3 symptoms indicates mild AUD, 4-5 moderate, and 6+ severe AUD.

Chapter 1

Table 1:   The 11 symptoms of alcohol use disorders, as stated in the DSM-5

1. Alcohol is often taken in larger amounts or over a longer period than was intended.

2. A persistent desire or unsuccessful efforts to cut down or control alcohol use.

3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

4. Craving, or a strong desire or urge to use alcohol.

5. Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home.

6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

8. Recurrent alcohol use in situations in which it is physically hazardous.

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

10. Tolerance, as defined by either of the following: a) a need for markedly increased amounts of alcohol to achieve intoxication or desired effect, b) a markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following: a) the characteristic withdrawal syndrome for alcohol, b) alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

The Alcohol Use Disorders Identification Test (AUDIT, Saunders *et al.*, 1993) is a validated alcohol screening tool, recommended by the National Institute for Health and Care Excellence (NICE), and can be used to detect drinkers at increasing or higher risk (World Health Organization, 2014). The AUDIT comprises 10 questions which ask about alcohol consumption, alcohol-related harm, and symptoms of alcohol dependence; responses to each item are scored from 0-4. Overall scores between 0-7 indicate low risk drinking, 8-15 increasing risk (or hazardous drinking), 16-19 high risk (or harmful drinking), and scores of ≥20 suggest probable dependence. Here, 'hazardous drinking' is defined as a pattern of alcohol consumption which increases the risk of harmful consequences for the individual; 'harmful use' describes consumption that causes physical and psychological problems; and 'alcohol dependence', the most severe form of AUD, is characterised by a cluster of behavioural, psychological, and physiological symptoms including craving, tolerance, preoccupation, and continued consumption despite negative consequences (Drummond *et al.*, 2016a; NICE, 2011). Figure 1 presents the distribution of drinkers in England in 2013/14, and maps

DSM-5 and ICD-11 AUD diagnostic labels. According to the Adult Psychiatric Morbidity Survey of households in England, 1.2% of individuals are probably dependent drinkers, scoring ≥20 on the AUDIT (Drummond *et al.*, 2016a).
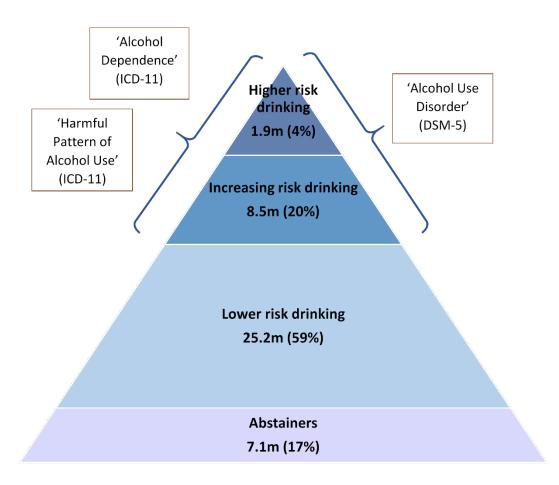
Figure 1:   The distribution of drinkers in England 2013/14, adapted from (Health and Social Care Information Centre, 2015; Public Health England, 2016)

Authors vary in their emphasis on the behavioural, psychological, and physiological components of the 'dependence' state. In its draft form, the ICD-11 incorporates all components, where individuals must meet two out of three criteria listed as: 1) impaired control over substance use, 2) substance use becomes an increasing priority in life, 3) physiological features (World Health Organisation, 2017). Although the DSM-5 removed the category of 'dependence', some argue it is still helpful to recognise for whom the ability to control the extent and frequency of consumption is diminished, or completely extinguished (Heather, 2013; McCormack *et al.*, 2013). The term 'addiction' is usually inferred to describe these behavioural and psychological features of dependence, in which an individual's motivation is driven by the procurement of a substance, despite the harm ensued (West, 2006); while physical symptoms of tolerance and withdrawal (as

defined in Table 1) may contribute to addiction severity, they are not necessary features of it (Raistrick *et al.*, 1994). Therefore, use of the terms 'addiction' and 'dependence' within this thesis refer to heterogeneous conditions associated with problematic alcohol use, which may or may not include physical symptoms. Unless discussing one component of the dependence state specifically (e.g. psychological, physiological), I use the term broadly to incorporate a range of experiences.

1.3   Treatment for alcohol problems

While not exhaustive, some common treatment approaches most relevant to the context of studies within this thesis, are briefly outlined below. Although NICE (2011) outlines ideal treatment pathways, determined in part by the nature and severity of alcohol use, in practice, treatment is rarely so straightforward (Gilburt, Drummond and Sinclair, 2015). Any intervention should be person-centred, and tailored to meet the goals of the individual (Savic and Lubman, 2018).

1.3.1   Identification and brief advice

Patients are often first diagnosed in a medical setting, perhaps when they are treated in hospital for an alcohol-related injury, or in primary care if routine blood tests show abnormalities (Connor, Haber and Hall, 2016). Opportunistic screening can result in identification of AUD and affords clinicians an opportunity to deliver tailored feedback about the person's alcohol use and any associated harm, advice about reducing intake (if relevant), and motivational support to boost confidence to change drinking patterns (Kaner *et al.*, 2007). Identification and brief advice (IBA), recommended by NICE (2010;2011), is therefore considered a first step in treatment.

Interventions in the research setting are usually delivered over one to four sessions and may last up to ~40 minutes. However, in busy clinical settings such as general medical practice, interventions typically last 5-10 minutes, and take the form of 'simple advice' (Heather, 2010). Trained staff in settings with more time available might deliver brief motivational interviewing (BMI, Rollnick, Heather and Bell, 1992), a more patient-centred and flexible form of IBA; here, the aim is not to offer 'catch-all' structured advice, but instead employ a goal-orientated counselling style to explore and resolve ambivalence about change. Irrespective of length and precise content, a fundamental goal of IBA is to increase patients' awareness of the problem and enhance motivation to address drinking patterns (Heather, 2014), consistent with the finding that motivation appears to be an important determinant of treatment outcome (Adamson, Sellman and Frampton, 2009).

Research into IBA in primary care settings in the UK suggests that it is an effective strategy for reducing alcohol intake, especially for males, with benefits estimated to include reduced alcohol-attributable mortality, fewer hospital admissions and NHS cost savings (Angus *et al.*, 2015; Kaner *et al.*, 2007; 2013). Similarly, a more recent meta-analysis assessing IBA within emergency departments found a small beneficial effect of the intervention (Schmidt *et al.*, 2016), although work within this setting tends to suffer high attrition, reducing the power of studies to detect effects, e.g. (Drummond *et al.*, 2014). While there is much to learn about alcohol interventions for general hospital inpatients, some research suggests that multiple sessions might be beneficial, especially for males and non-dependent drinkers (McQueen *et al.*, 2011; Mdege *et al.*, 2013).

Critics of IBA note the discrepancies between efficacy trials and effectiveness of IBA in clinical practice (McCambridge and Saitz, 2017; Saitz, 2014), and suggest that while interventions might alert patients to the need to seek treatment, they often do not help them to access it, or empower them to make tangible changes (Glass *et al.*, 2015). Nevertheless, others have argued that there are benefits and no harm from screening, except for the opportunity costs (Jonas *et al.*, 2012). Supporting this, results from randomised IBA trials show that even non-intervention control groups reduce their alcohol consumption throughout, e.g. (Bischof *et al.*, 2012), perhaps because of the inadvertent exposure to a vital component of the intervention – assessment of drinking (Kypri *et al.*, 2007; McCambridge and Kypri, 2011).

1.3.2   Medically assisted withdrawal

Due to the physical and psychological complications arising from excessive alcohol consumption, use of secondary healthcare services is not uncommon (Institute of Alcohol Studies and Centre for Mental Health, 2018; PHE, 2018a). While patients may present with a range of ailments, assessment for, and treatment of, acute alcohol withdrawal in physically dependent patients is imperative, as the consequences can be life threatening. Alcohol withdrawal syndrome (AWS) is caused by a sudden cessation or reduction in alcohol consumption, and symptoms include anxiety, agitation, nausea, sweating, tremor, tachycardia, and hypertension (American Psychiatric Association, 2013; World Health Organisation, 2017); patients with severe AWS may suffer seizures and delirium tremens, characterised by intense tremor, fever, delusions, hallucinations, and confusion. Long-acting benzodiazepines (chlordiazepoxide and diazepam) are recommended for AWS management, as well as detoxification from alcohol ('detox') in hospital (Lingford-Hughes *et al.*, 2012).

Patients may present to the emergency department already in alcohol withdrawal, or symptoms may develop somewhat unexpectedly during an admission that is not overtly alcohol-related;

general hospital staff are therefore able to reach patients who may not perceive themselves as alcohol-dependent, and work with them to increase motivation to address problematic alcohol use (Gaume *et al.*, 2014). Despite assumptions that medically assisted withdrawal as an inpatient should be planned and reserved for motivated patients who are less likely to drop out of treatment early (Berg and Dhopesh, 1996), recent evidence supports unscheduled detoxification directly linked to emergency departments (Azuar *et al.*, 2016). Azuar and colleagues (2016) found that despite higher AUD severity, patients with unscheduled 'detoxes' did not differ in early dropout rate compared to patients whose detoxes were planned, and there was no difference in attendance rate of post-discharge treatment visits. While promising, more research is needed to explore the role of unscheduled general hospital detoxes which considers other important outcomes (e.g. subsequent consumption, levels of dependence), and patient perspectives of such treatment.

In 2001, the Royal College of Physicians recommended that all major UK hospitals should establish specialist alcohol care teams (ACTs) to work to reduce alcohol-related hospital admissions (Royal College of Physicians, 2001). Such teams, led by a senior clinician, should be able to provide comprehensive alcohol use assessments, medically assisted alcohol withdrawal management, coordination of safe discharge and liaison with specialist treatment services (Section 1.3.3), IBA, and psychotherapeutic interventions (PHE, 2014). There is limited evidence for the effectiveness of hospital ACTs, although some early research finds positive outcomes in terms of reduced bed days (Moriarty, 2010; Ryder *et al.*, 2010), alcohol use and dependence severity (Cobain *et al.*, 2011; Crawford *et al.*, 2004), and reattendances (Crawford *et al.*, 2004). Few qualitative studies have explored the impact of an unscheduled hospital attendance/admission on patients' thoughts about their relationship with alcohol, and their views of interventions delivered within this setting. Although the last few years have seen an increased interest in this area, e.g. (Clark *et al.*, 2017; McQueen, Ballinger and Howe, 2017; Neale *et al.*, 2017; Parkman *et al.*, 2017a; 2017b; Velez *et al.*, 2017), there is a gap in the literature for UK-based studies of patients with diverse alcohol use and treatment histories, and hospital experiences (e.g. emergency department vs. inpatient stays).

1.3.3 Specialist alcohol treatment

It may be necessary to refer patients for specialist alcohol treatment if their needs extend beyond the role of brief interventions, or if they request additional, ongoing support (Day, Copello and Hull, 2015). 'Alcohol-focused specialist treatment' is an umbrella term used to describe a host of pharmacological and psychosocial interventions. A review of the evidence base for interventions can be found in several published papers, e.g. (Lingford-Hughes *et al.*, 2012; Martin and Rehm,

2012; Raistrick, Heather and Godfrey, 2006). With respect to psychosocial therapies (e.g. cognitive-behavioural interventions, Motivational Enhancement Therapy, Social Behaviour and Network Therapy), different treatments appear equally effective in reducing consumption and overall alcohol-related problems (Allen *et al.*, 1997; Martin and Rehm, 2012; UKATT Research Team, 2005). Moreover, regardless of treatment modality, strong therapeutic alliances, and therapist characteristics (e.g. fidelity, interpersonal skills, allegiance to certain treatment models) are suggested to be important predictors of engagement and outcome (Meier, Barrowclough and Donmall, 2005; Miller and Moyers, 2015).

Specialist treatments may be delivered within the context of inpatient rehabilitation centres, therapeutic communities, or through outpatient/community services. Upon referral to specialist services, NICE (2011) recommends staff complete a comprehensive assessment which extends beyond drinking patterns; assessment domains should include physical and psychological health problems, other drug use, cognitive functioning, and readiness/confidence to change behaviour. This is used to inform the development of person-centred, tailored care plans, and help guide treatment. Some patients might benefit from full care co-ordination or 'case management' which involves more intensive, ongoing contact offering non-judgemental supportive interaction to monitor alcohol use and other areas of functioning (Day, Copello and Hull, 2015; Drummond *et al.*, 2016b). However, this represents an ideal, whereas the reality is that services often struggle to resource and deliver high quality care that meets the needs of patients, especially those with complex needs and co-occurring mental health problems (Alcohol Concern and Alcohol Research UK, 2018; Institute of Alcohol Studies and Centre for Mental Health, 2018). Indeed, a recent report by Alcohol Concern and Alcohol Research UK (2018) highlighted that just 12% of stakeholders involved in alcohol treatment services in England felt that resources are sufficient in their area.

1.3.4   Mutual aid or self-help

Mutual aid groups are self-organising groups that allow people with similar experiences to help each other though the provision of social, emotional, and informational support; they play an important role for many people seeking recovery from alcohol dependence and can also offer support for others affected by addiction, such as partners and family (PHE, 2013a). The 12-step programme (e.g. Alcoholics Anonymous, AA) is probably the most well-known form of mutual aid, although a variety of other groups are gaining popularity (Parkman, Lloyd and Splisbury, 2015), including those based online, e.g. (Bergman *et al.*, 2017; Coulson, 2014; Cunningham, van Mierlo and Fournier, 2008; Hester *et al.*, 2013; Humphreys and Klaw, 2001; Pennay, MacLean and Rankin, 2016; Sinclair, Chambers and Manson, 2016).

Research into the 'active ingredients' of mutual aid has suggested they provide a source of structure and goal direction, exposure to recovery role models, and bolster effective coping skills (Moos, 2008), although most work has focused on AA (Parkman, Lloyd and Splisbury, 2015). Online support may act as a stepping stone for people accessing in-person treatment, or it may serve as an aid to natural recovery in others. The anonymous nature of online groups allows users to self-disclose more freely and intensely than they would in person and could provide non-judgmental space to begin the recovery process with reduced fear of stigmatisation (Cunningham, Kypri and McCambridge, 2011; Khadjesari *et al.*, 2015). Kelly recently asserted that mutual aid is "the closest thing we have to a free lunch in public health" (2017, p.3); irrespective of form, clinicians should therefore encourage attendance alongside professional treatment (Best, 2017; National Institute for Health and Care Excellence, 2011; Public Health England, 2013a).

1.3.5 The treatment utilisation gap

In the context of a discussion of treatment options, it is pertinent to highlight the large gap between those meeting criteria for AUD, and those receiving help (Drummond *et al.*, 2011). Less than 15% of alcohol-dependent individuals in England received specialist treatment in 2016/17, according to data obtained from the National Drug Treatment Monitoring System (NDTMS, PHE, 2017). There is also often a significant gap between AUD onset and treatment access, with international data showing a delay of up to 18 years (Wang *et al.*, 2007). Despite free access to care under the NHS in the UK, Bunting and colleagues (2012) still found significant delays in treatment seeking in Northern Ireland, and the same might be assumed for the rest of the UK.

Failure to seek help early may be due to several factors including: cultural norms of heavy drinking, a desire to handle the problem alone, missed opportunities to identify those who would benefit from treatment, poorly developed care pathways, and limited resources/access to specialist services (Cunningham *et al.*, 1993; Tucker and Simpson, 2011). Another recurring theme is that alcohol dependence is a particularly stigmatised condition (Wallhed-Finn, Bakshi and Andréasson, 2014) which often evokes negative emotions and social rejection, more so than other substance-unrelated mental disorders (Schomerus *et al.*, 2011a). Negative attitudes are prevalent even amongst healthcare professionals, and can act as a barrier for people seeking help (Keyes *et al.*, 2010), or lead to sub-optimal treatment if patients do come forward (van Boekel *et al.*, 2013). Moreover, using extreme examples of harm and dependence as benchmarks for problematic drinking, reduces the likelihood of individuals drinking at risky levels perceiving their consumption to be problematic and seeing the need for treatment (Khadjesari *et al.*, 2018). This supports work which finds that individuals in treatment are consistently found to have more severe AUD, report greater adverse consequences from drinking, have a history of prior help-seeking and often

display additional complex difficulties (Rehm *et al.*, 2015; Rohn *et al.*, 2017; Storbjörk and Room, 2008; Tuithof *et al.*, 2016).

Despite the significant treatment utilisation gap, clinical addiction research has disproportionately focused on patients with severe dependence in specialist settings (Andréasson, 2012; Cunningham and McCambridge, 2011). This may have contributed to early conceptualisations of alcohol problems which divided the population into two distinct categories or "worlds" – the in-treatment 'clinical' population vs. the hidden 'non-clinical' population (Room, 1977; Storbjörk and Room, 2008), and fuelled binary beliefs about addiction, e.g. case/non-case, diseased/healthy (Moore *et al.*, 2017; Pienaar *et al.*, 2016). However, evidence that AUD are underpinned by a single latent construct (Borges *et al.*, 2010; Saha, Chou and Grant, 2006) suggests that they should instead be understood as existing on a continuum of severity. Moreover, polarised views of the 'worlds of alcohol problems' have been challenged by a growing integrative literature base which highlights similarities between the two worlds, e.g. (Matzger, Kaskutas and Weisner, 2005), and that recovery can occur through multiple and intertwining pathways (Christensen and Elmeland, 2015; Kougiali *et al.*, 2017; Tucker, 2005).

As per DSM-5 guidelines, the presence of any ≥2 symptoms (Table 1) is indicative of AUD. This results in >2000 possible combinations of symptoms and highlights the heterogeneity of the disorder. Consequently, several authors have called for more research to understand how people with a *range* of drinking patterns, and those who do not seek specialist treatment, view their relationship with alcohol, e.g. (Andréasson, 2012; Ondersma *et al.*, 2017; Pienaar and Dilkes-Frayne, 2017; Tucker and Simpson, 2011). Although the inclusion of participants with high risk characteristics (e.g. psychiatric comorbidities, concurrent drug and alcohol use, homelessness) poses a challenge for recruitment, and muddies the water for data analysis and interpretation, complex presentations are typical in clinical practice (PHE, 2016) and should be the population to study rather than exclude in research (Blanco *et al.*, 2008; Kim *et al.*, 2017).

With these considerations in mind, studies within this thesis were designed to broaden understanding about problematic alcohol use and recovery, by focusing beyond what 'works' for a small minority of treatment seekers in specialist clinical settings. A key interest of this thesis is to explore participants' perception and subjective experience of AUD and associated recovery processes. Broad inclusion criteria sought to identify people with a range of drinking patterns and treatment histories to generate theory about potential mechanisms of action that might underpin change.

1.4   The recovery paradigm

The shift toward a recovery paradigm is evident in research, treatment, and policy, and the concept has found its way into everyday discourse (White, 2008). Professional treatment models often favour sustained-care recovery management over acute stabilisation (el-Guebaly, 2012; Hser and Anglin, 2010; Laudet, 2008) and there is an increase in the number and popularity of peer-led mutual aid groups which often consider recovery as an ongoing (sometimes lifelong) process. Attempts to integrate the fields of addiction and mental health have also used recovery as a conceptual bridge (Davidson and White, 2007; Gagne, White and Anthony, 2007; Skogens, von Greiff and Topor, 2018), although in policy and practice, care for individuals with co-occurring conditions is poor (Institute of Alcohol Studies and Centre for Mental Health, 2018).

Despite this increased interest in the 'recovery' concept, there is still no universally accepted definition of the term (Laudet, 2008; Neale *et al.*, 2014; White, 2008), even amongst those who consider themselves to be 'in recovery' (Laudet, 2007; Neale *et al.*, 2015). Many influential definitions have emphasised the importance of abstinence and refer to 'objective' observable outcomes across a range of domains of functioning. For example, in the United States, the Betty Ford Institute Consensus Panel defined recovery as "a voluntarily maintained lifestyle characterised by sobriety, personal health, and citizenship" (Belleau *et al.*, 2007, p.222). This definition is commended for its acknowledgement that recovery is an ongoing process rather than a static state (Best and Laudet, 2010). However, the Betty Ford treatment service is 12-step based which is likely to have influenced the panel's viewpoint, particularly around the necessity of abstinence. In the UK, the Drug Policy Commission statement characterises recovery as "voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society" (2008, p.6), and the 2013 Advisory Council on the Misuse of Drugs report states that recovery "covers a number of outcome domains and is a wider concept than purely overcoming drug and alcohol dependence" (p.9).

Outcome-orientated definitions predispose measures of recovery to focus on quantifiable indicators of change, including reductions in consumption and offending behaviour (Neale *et al.*, 2015). Some drug and alcohol treatment providers in the UK are even incentivised and remunerated for demonstrating 'successful' recovery outcomes according to such measures, as part of the Payment by Results (PbR) scheme (HM Government, 2010). In contrast to definitions operationalised according to quantitative outcomes, patient-centred perspectives on recovery tend to place more emphasis on the subjective experience of change, which may or may not involve abstinence (Klingemann, Sobell and Sobell, 2010; Witbrodt, Kaskutas and Grella, 2015). Valentine (2010), for example, suggests that "you are in recovery if you say you are" (p. 264).

White (2007) also argued for keeping personal experience at the heart of definitions of recovery, but provided an extended description of recovery which incorporates the role of social networks and internal and external resources from which the individual can draw upon:

> "Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life." (p.236)

More recent research, conducted with individuals with personal experience of addiction, highlights the importance of service-user input when designing tools to measure and track recovery (Neale and Strang, 2015; Neale *et al.*, 2015). Participants identified numerous problems with existing measures, including: items that contradicted each other and/or were written using inappropriate language, a failure to recognise individual differences, and items that measured changes beyond personal control or capability, i.e. expecting individuals to "become superhuman" (Neale *et al.*, 2015, p.29). These findings highlight that failure to recognise subjective experience of recovery can result in inappropriate and unrealistic measures, which is concerning when their outcomes often guide treatment and policy decisions, further impacting individuals' care (Dwyer and Fraser, 2016).

A further problem with many definitions of recovery, as Best et al. (2016) argues, is their failure to account for mechanisms of change; descriptions of the *characteristics* of a person who we might identify as being 'in recovery' do not equip us to assist them in their recovery journey. Furthermore, studies that do explore change, often employ causal designs involving assessment pre- and post-intervention(s) to fulfil the need for evidence on what 'works' for individuals with addictions (Kougiali *et al.*, 2017); this conceptualisation of change as fixed and unidirectional is challenged by some research showing recovery to be discontinuous and non-linear (Hayes *et al.*, 2007). A recent study by Kougiali and colleagues (2017) collected life stories from individuals at various stages of recovery and use of different substances, and found that personal trajectories comprised circuitous and enduring patterns of recurring and interchangeable episodes of abstinence and relapse. Importantly, relapse, although seen at the time as a failure, was considered fundamental to the learning process which aided, rather than hindered change. The authors concluded that many periods of long-lasting instability precede long-term recovery, which short-term pre-post outcome studies fail to capture. Their research highlights the importance of exploring *how* a person changes (i.e. the process of recovery) – and not only whether they have changed.

1.5 Introduction to identity in addiction and recovery

As recently noted by Best and colleagues (2017a), to date, much research on addiction recovery has assumed homogeneity across experiences, recovery philosophies and treatment approaches. However, evidence increasingly suggests that experiences of addiction and recovery are intricately entwined with the person's sense of self, or 'identity' (Kellogg and Tatarsky, 2012; Lindgren *et al.*, 2017), and a 'one size fits all' approach will fail to capture the complexities of individual experience (Savic and Lubman, 2018); personal (and social) conceptualisations of alcohol problems and recovery are suggested to be important influences on intervention/treatment receptivity and openness to change (Best *et al.*, 2017a; Best *et al.*, 2014). Supporting this, a recent study found that heavy drinkers *who perceived themselves as such* expressed more desire to reduce their consumption than those who perceived themselves to be lighter drinkers; judgements about levels of alcohol use, independent of actual consumption, predicted desire to reduce (Shiner and Winstock, 2015). Furthermore, beliefs about the nature, or philosophy, of alcohol problems (e.g. whether one ascribes to the disease model) are likely to affect recovery-based identities, and the labels used to describe them, e.g. an 'ex-drinker', a 'recovering alcoholic' (Best *et al.*, 2017a; Doukas and Cullen, 2009; Young, 2011a).

While several theories of addiction and recovery include elements related to self and identity, this area is considerably under-researched (Best *et al.*, 2017a; Corte, 2007; Lindgren *et al.*, 2017). The following sections provide an overview of key theories to orientate the reader to the area of identity in addiction and recovery. Details of specific studies are presented in subsequent chapters where they enhance theoretical understanding of my own research data. However, the evidence discussed here aims to highlight that further examination of the relationship between matters of identity and recovery from problematic alcohol use might be fruitful. As there is limited research focusing on identity and alcohol use specifically (particularly outside of an AA context), work looking at recovery from other substances is included.

1.5.1 Defining identity

Broadly speaking, identity or 'self-concept' is understood as a collection of ideas or beliefs about the self (Corte, 2007). It enables individuals to organise past and present experiences, guides them to future opportunities, and often directs behaviour; it is a "roadmap detailing how one goes about being oneself" (Oyserman, 2007, p.432). Self-concept can appear both stable, containing features that are relatively constant, and fluid, allowing the person room to develop and grow (Oyserman, 2007). While cognitive models of self often present identity as a personal phenomenon, many scholars have recognised the role of situational and social cues in shaping an

individual's sense of self. For simplicity, personal and social identity theories are presented separately below, although this divide is artificial and there is often considerable overlap. It is important to reiterate that the following sections do not present a systematic review of all identity theories, of which there are dozens. Rather, they provide an orientation to the concept of identity in relation to addiction and recovery which served as the foundation upon which to build this work.

In the literature, cognitions about the self in relation to addiction have been termed: *self-concept, sense of self, self-schema*, and *identity* (Lindgren *et al.*, 2017); I use these terms interchangeably throughout this thesis, with preference given to the words used by participants in each study.

1.5.2 Personal identity

1.5.2.1 General theories

The schema model (Markus, 1977; Markus and Wurf, 1987), originating from cognitive psychology, was intended as a middle-range theory of the self-concept. It suggests that the self-concept is a complex internal cognitive system made up of multiple units of knowledge about the self, called self-schemas. These cognitions can be explicit or implicit. Explicit self-schemas rely on deliberate introspection on behalf of the individual, consistent with the notion that people learn about who they are from observing their own behaviour (Bem, 1972). Implicit self-schemas, by contrast, are activated unconsciously and reflect reflexive and impulsive cognitions. All schemas are hypothesised to be organised in a network of meaningful domains that are important or valued by the person; they reflect what the individual thinks and cares about and pays attention to. Individuals are motivated to act in ways congruent with their self-schemas (Oyserman, 2007;2009), and even misremember information to perpetuate their own schemas (Bower and Gilligan, 1979; Greenwald, 1980). Repeated exposure to schema-consistent experiences and information reinforces and strengthens the self-schema, often causing contradictory information to be resisted (Markus, 1977).

West's (2006) PRIME theory is proposed as a comprehensive addiction-specific model of motivation to explain what energises and guides behaviour, which like schema theory, emphasises the role of self-concept. PRIME theory derives its name from five hypothesised levels of motivation: Plans, Responses, Impulses, Motives, and Evaluations. Of particular relevance to this discussion is the role of motives (the things we want and need, and act in pursuit of), and evaluations (beliefs about what is good/bad or right/wrong). West argues that one's identity is a key source of wants and needs, and it is this which guides behaviour (like drinking alcohol); as identity is a representation of what individuals typically consider most important – their selves – it

is pursued with more commitment and desire than other mental representations (2006, p.164). In PRIME theory, identity includes *labels* (categories of belonging, e.g. 'alcoholic'), *attributes* (ascribed features, e.g. 'rebellious') and *personal rules* (conditions of behaviour, e.g. not drink in the morning). Current and possible future identities, to which one is emotionally attached, influence behaviour because of their power in driving wants and needs (Oyserman and James, 2011; West, 2006). Beliefs about what is good or right (evaluations) only influence behaviour if they create sufficiently strong wants or needs in a given moment.

1.5.2.2   Personal identity in addiction and recovery

In terms of the impact of addiction on identity, early work suggested that at the level of dependence, alcohol becomes the dominant framework of self from which behaviour is guided (Edwards and Gross, 1976); alcohol-related thoughts become enmeshed with the individual's definition of self, such that the alcohol self-concept becomes a "master identity that overrides all other [self] conceptions the alcoholic has" (Denzin, 1993, p.97). Other scholars have referred to this process as "entangling" (Gibson, Acquah and Robinson, 2004) or "spoiling" (Biernacki, 1986) of identity. Thus, an 'alcoholic self-concept' may be the cognitive product of repeated engagement in behaviours that perpetuate a drinking schema (Corte and Stein, 2007; Domenico *et al.*, 2017). Supporting this, more recent qualitative work has found that one pathway into addiction involves the loss of positive identities combined with an increased 'user' self-concept (Dingle, Cruwys and Frings, 2015). The all-consuming nature of addiction is also evident in the DSM-5 criteria for AUD, with greater disorder severity marked by increasing number of symptoms (see Table 1 earlier). Furthermore, the dominant 'addict' self-concept, when considered an important source of wants and needs, explains how individuals can engage in behaviours they might evaluate as bad or wrong (West, 2006).

While most recognise the overwhelming impact that addiction can have on one's sense of self, establishing the role of identity in *recovery* is arguably a more difficult feat. Bailey asks, "in what sense can someone who has been labelled, or labelled themselves, an 'addict' ever move beyond that discourse?" (2005, p.537). Put another way: how is recovery possible for someone whose identity is defined by their addiction?

Some studies suggest that constructing a transformational narrative of identity from a user to a non-user is necessary for long-term change (Gibson, Acquah and Robinson, 2004) – whether that means "becoming a better person", or "reclaiming a self" lost to addiction (el-Guebaly, 2012). Supporting this, those in recovery do appear to abandon substance-related self-concepts (Corte,

2007; Corte and Stein, 2007), and instead form new beliefs and definitions of self that are incompatible with addictive behaviours, e.g. (Dingle, Cruwys and Frings, 2015; McIntosh and McKeganey, 2001). Understanding recovery in terms of establishing an 'unspoiled identity' stems from work examining the narratives of ex-drinkers/users, but also accords with policy which seeks to successfully reintegrate those with substance use problems back into mainstream 'responsible' society (Neale, Nettleton and Pickering, 2011; PHE, 2016).

Kearney and O'Sullivan's (2003) paper provides a formal theory[2] to explain the process by which one might transition from a 'user' or 'drinker' to an 'ex-user/drinker'. Using a grounded theory approach, they synthesised the findings of 14 published qualitative studies of behaviour change (including weight loss, smoking cessation, and drug/alcohol recovery) and proposed an 'identity shift theory'. The starting premise is that a 'turning point' moment prompts a small step towards behaviour change. Importantly, this moment is not defined as a specific crisis event, but rather a critical self-appraisal in response to "distressing accumulated evidence" that behaviour conflicts with life goals and values (p.142). If the small step towards change is successful, in that it sparks the development of a new identity which excludes the problem behaviour, more behaviour change will follow, which in turn strengthens the new identity, again enabling new behaviours. Thus, the theory proposes a dual process model where behaviour change and identity shifts interact recursively to generate sustained change. PRIME theory (West, 2006) also recognises the relationship between identity and behaviour change; here, recovery is facilitated through the development of a deep emotionally-laden identity that requires: 1) absolute rules that exclude addictive behaviours, 2) renouncement of addictive behaviours as attractive, and 3) a commitment to self-label as a 'non- or ex-addict' (Vangeli and West, 2012; West, 2006).

While Kearney and O'Sullivan (2003) usefully synthesised evidence of behaviour change across a range of studies, their theory relies on secondary data available in published papers. Furthermore, unlike West's specification of the three steps required to implement change, Kearney and O'Sullivan are not clear about what establishing a 'new identity' really entails. They do however highlight various constraints that impede successful change (e.g. lack of confidence, social pressure for the old identity, lack of support to sustain the new identity, chaotic lifestyle, presence of temptations etc.). One further limitation of both identity shift theory and PRIME is that neither are specific to recovery from problematic alcohol use. While PRIME theory is

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[2] I use the term 'formal theory' to differentiate it from substantive theory, where the latter offers an account of processes in one specific, substantive area (Lempert, 2007, p.246-7). Kearney and O'Sullivan's (2003) theory of identity shifts aims to explain behaviour change processes with more generalisability and conceptual reach than a substantive theory would.

intended as a broad theory of addiction, most work supporting it involves (ex)smokers. There is some evidence to suggest substance-specific differences in routes to recovery, e.g. (Blomqvist, 2002; Hanninen and Koski-Jannes, 1999; Koski-jännes and Turner, 1999), thereby supporting the necessity of more alcohol-specific research.

As mentioned above, one of PRIME's hypothesised requirements for behaviour change to occur is the commitment to self-label as a 'non- or ex-addict'. However, there is lack of consensus in the literature about the necessity of accepting an 'addict' identity before being able to progress in recovery (Doukas and Cullen, 2009), and this is likely to vary as a function of philosophical differences in beliefs about the nature of addiction (Best *et al.*, 2017a). For example, the 12-step philosophy which underpins AA, rests on members accepting they have an "incurable disease" (Reith, 2004, p.293), and members are encouraged to adopt a totalising 'alcoholic' identity (Bathish *et al.*, 2017; Cain, 1991). This state of permanency is epitomised in the well-known self-introduction at AA meetings: *"Hello, my name is _____ and I am an alcoholic"* (said even after years of sobriety). Similarly, Fiorentine and Hillhouse's (2000) 'addicted self model' asserts that it is fundamental for the individual to accept their substance use as a permanent condition or state; the authors suggest that maintaining an addicted self-concept, even during sobriety, increases the likelihood of life-long recovery because the individual is reminded of their low self-efficacy to control substance use. However, empirical support for the model is confined to a single investigation, and other results reside in an "unpublished manuscript" (Fiorentine and Hillhouse, 2000, p.514). Nevertheless, research with AA/NA members has supported the benefits of adopting an addict/recovering-addict identity for recovery, e.g. (Buckingham, Frings and Albery, 2013; Hill and Leeming, 2014; Weegmann and Piwowoz-Hjort, 2009), although this is likely to be entwined with social identity processes associated with group membership, described in the next section.

While little is known about the recovery identities of those not engaged with AA (Parkman, Lloyd and Splisbury, 2015), one study found that labels such as 'recovering alcoholic' can limit personal growth and self-perception, prompting some individuals to go through an active process of "de-labelling" (Howard, 2006). Although many of Howard's participants found their disorder label helpful in early recovery, in that it provided a useful starting place to make sense of their experiences, they later felt "the means to recovery [i.e. taking on a disorder label] was becoming an end in itself" (p.317). Interestingly, participants did not attribute their decision to 'de-label' as a mechanism for dealing with stigma, but purely to free internal limits imposed by disorder self-identification.

However, labels can evoke stigma and/or shame, especially when they become descriptors of an essentialising identity from which the person derives their entire sense of self (Fraser *et al.*, 2017; Fraser and Treloar, 2006); this is one concern with synonymising addiction with a 'spoiled' identity, and recovery with an 'unspoiled' identity (Neale, Nettleton and Pickering, 2011). Moreover, as Hughes (2007) argues, recovery is in part dependent on the "willingness of others to engage in, and support" change (p.688) – holding the individual wholly responsible for transforming their 'spoiled' identity neglects the function of sources external to the individual, including social roles and group memberships, introduced in the next section.

1.5.3 Social identity

1.5.3.1 General theories

Two theories of social identity, situated within the field of psychology, have provided important bases for addiction-specific research described in the next section, and therefore warrant brief mention. Social identity theory (SIT, Tajfel and Turner, 1979) posits that an individual's self-concept is derived from their membership to social groups; these social identities provide a framework for a person's values, norms, goals, and behaviour. SIT contends that individuals are motivated to pursue a positive self-concept and will work together to emphasise positive aspects of the social groups they belong to, often by making comparisons with out-groups. Groups strengthen as individual members become emotionally attached to, and psychologically intertwined with, the shared goal (Tajfel and Turner, 1979). Group membership is found to be a source of positive self-esteem, and beneficial effects found for physical and mental health (Jetten, Haslam and Alexander, 2012). Self-categorisation theory (SCT, Turner *et al.*, 1987) is an extension of SIT which emphasises the cognitive processes involved when individuals categorise themselves, and others, as group members. SCT suggests that when an individual self-categorises as a group member, they come to see themselves as similar to others in the group (termed *depersonalisation*); the more representative a person is in terms of group characteristics and attributes, the greater status they occupy within that group.

While SIT and SCT are specific theories of intergroup behaviour (Tajfel and Turner, 2004), Goffman's (1959) work on dramaturgy provides a helpful, more general perspective on the role of social interaction in identity construction. Goffman used the metaphor of a theatre to describe how social actors 'performed' their roles, which vary depending on their audience. He argued that identity is constructed through interaction with others, and actors may convey different identities to different audiences at different times, employing strategies such as *impression management* –

identities are therefore negotiated and subject to constant change. Performances can also involve collaborations between multiple actors (i.e. groups) to stage a "single routine" (p.85).

Like a theatre, an individual's identity comprises a 'frontstage' region of deliberate, visible performances, and a 'backstage' region which protects hidden aspects of self; Goffman comments: "behind many masks and many characters, each performer tends to wear a single look, a naked unsocialised look" (1959, p.228). Audiences continually analyse performances, taking note of deliberate impressions (e.g. verbal communications), and expressions the actor might 'give off' unintentionally (e.g. dress, body language). In the same vein, Goffman identified two types of social identity: the 'actual' (a set of characteristics the individual truly possesses) and the 'virtual' (a constructed image of desired characteristics). Individuals are motivated to maintain harmony between both types of social identity, and both types of impression. Failure to do so can give rise to stigma and is "deeply discrediting" to the person's virtual identity (Goffman, 1963, p.13).

1.5.3.2   Social identity in addiction and recovery

Observations of the beneficial effects of recovery group membership for a range of outcomes including psychological well-being and consumption levels, e.g. (Kelly, 2017; Kelly *et al.*, 2012a; Moos and Moos, 2007), has prompted a more thorough investigation of the relationship between group involvement and recovery. With SIT and SCT as a foundation, a growing body of literature has suggested that group memberships can encourage the development of a new, positive social identity that is conducive for recovery. Buckingham and colleagues (2013) were among the first to investigate this relationship empirically. Recruiting members from AA and NA (Narcotics Anonymous), and a sample of ex-smokers, they identified two processes through which recovery-based group membership might operate: 1) *'evaluative differentiation'* where the individual comes to evaluate their recovery identity positively because of the derogation of their old 'addict' identity, and 2) *'identity preference change'* where the individual more strongly identifies with their recovery identity to maintain a positive sense of self. Both processes were associated with less relapse and appetitive behaviour, although the effects of identity preference appeared to operate through its positive impact on self-efficacy. The authors concluded that developing a social identity aligned to recovery, and subsequently making explicit the differences between the new and old identities, may be beneficial for successful long-term recovery.

Two recent theories, drawing on SIT and SCT, have been developed to synthesise work around recovery and social identity: the social identity model of cessation maintenance (SIMCM, Frings and Albery, 2015), and the social identity model of recovery (SIMOR, Best *et al.*, 2016). The former takes a *social cognitive* perspective where identities are activated cognitively (either implicitly or

explicitly) through cues in the environment. Membership to recovery groups is thought to strengthen the activation of recovery-based identities, and provides a network of social support which involves giving advice about strategies to cope with difficult situations, encouragement after a lapse or relapse, sharing stories of personal recovery, and conveying hope about the future (Frings *et al.*, 2016). The same goal unites members and provides a structure for group norms (e.g. the AA norm of abstinence); internalisation of these norms motivates the individual to enact group-congruent behaviours and therefore reduces the risk of relapse. As group membership strengthens, so does activation of a recovery-based identity, sufficiently so that over time it becomes readily accessible in situations beyond the group environment, e.g. at a party where drugs or alcohol might be present (Frings and Albery, 2015).

SIMOR, while complementary to SIMCM, has a different emphasis (Best *et al.*, 2016). Here, social identity transitions are said to take place within a changing social landscape, from a *systemic*, instead of a cognitive/individual perspective. SIMOR also suggests that recovery-based identities can derive from sources beyond recovery group membership (e.g. socialising with non-drinking friends). Another difference between the theories is that SIMOR explicitly describes several stages within the recovery process, and highlights that group memberships, and consequently social identities, are continually evolving and being negotiated (Best *et al.*, 2016). This aligns with Goffman's (1959) conceptualisation of multiple social performances which play a role in shaping identity over time.

Best et al. (2016) suggest that in SIMOR, early stages of recovery are defined by ambivalence because of engagement with recovery groups alongside a salient social identity linked to active substance use. Later phases of recovery are defined by a stable non-drinking social identity fostered through engagement with pro-abstinent groups. Transitions in social networks coincide with the establishment of a new recovery-based social identity that supersedes the old 'addict identity'; continued affiliation with positively-valanced recovery-orientated groups promotes self-esteem and helps to create psychological distance between the new and old identity.

Neale and colleagues (2011) note that the pressure on individuals to rid themselves of a 'spoiled' identity and create an entirely new identity can lead to hopelessness and disempowerment. Drawing on Goffman's dramaturgical perspective to recovery, they suggest that even before making any change to substance use, individuals can conduct positive social performances to begin *some* constructive identity work: "In every new encounter, there is opportunity to be thoughtful and considerate, minimise previous identity damage and project a more positive self" (p.6). Involvement with recovery groups provide members additional opportunities to engage in a social script where recovery is the central storyline (Murphy, 2013). Frontstage work involves the

use of props (e.g. the 'Big Book' of AA) which guide members in group etiquette. Strict adherence to the group performance facilitates individual and collective recovery experiences, and backstage work involves private consolidation of collective scripts. Practicing recovery-based performances strengthens the recovery identity (Murphy, 2013), and might explain why many remain in recovery circles, even after years of sobriety, to help others at earlier stages of change (Zemore and Kaskutas, 2004).

1.6   Summary

Understanding of the relationship between identity processes in addiction and recovery is limited. However, the past few years have seen renewed interest in this field, with researchers finally responding to calls from scholars decades ago, e.g. (Biernacki, 1986; Cain, 1991; Denzin, 1993; Kellogg, 1993; Walters, 1996). Nevertheless, more needs to be done to synergise knowledge on this topic. It is necessary to explore the constructs of identity which are important in recovery, encompassing, but going beyond, a recognition that both personal and social identity are implicated. For example, philosophical assumptions of addiction and recovery (e.g. addiction as an incurable disease, recovery as a lifelong process etc.) are likely to be crucial determinants of the type of identity change a person might experience, and although seemingly obvious, it is a consideration that has been largely neglected in the literature (Best *et al.*, 2017a). Moreover, although work has explored "triggering" or "turning point" events that may prompt an individual to seek treatment, e.g. (Orford *et al.*, 2006a; Orford *et al.*, 2006b), few researchers have assessed the impact these may have on conceptualisations of addiction and recovery, and corresponding identities. Recovery is a heterogeneous phenomenon, and therefore the processes which underpin it, including identity transitions, are also likely to be heterogeneous. Work focused on those with a range of drinking patterns and in settings beyond specialist treatment services, including AA, is needed to fully explore this heterogeneity.

Chapter 2 RESEARCH APPROACH

2.1 Introduction

The scoping literature review presented in the previous chapter identified that further research is needed to understand experiences of living with and beyond problematic alcohol use, particularly for individuals not currently engaged in specialist treatment or 12-step fellowships. This chapter discusses pragmatism as the philosophical framework guiding my research and justifies the mixed-methods grounded theory approach used to address this gap in literature.

2.2 Philosophical paradigms in research

In designing their studies, researchers are guided by a basic set of beliefs about *ontology* (what is the nature of reality?), *epistemology* (what is the relationship between the knower and the known?) and *methodology* (how do we gain knowledge of the world?) (Guba, 1990). Together, these beliefs form what have been termed a 'paradigm', or 'worldview'. Morgan (2007) explains that paradigms are *a priori* philosophical systems that impose order on research; each paradigm with its defining set of beliefs places certain demands on the researcher and will determine the questions asked, the data collection methods used, and interpretations formed.

Positivism and constructivism are two of the main research paradigms. Positivism assumes the existence of a single reality and contends that hypothesis-testing scientific methods can harness objective information about this reality; the researcher is separate from the researched (Teddlie and Tashakkori, 2009). Positivists rely on quantitative data collection methods to describe phenomenon under investigation and at an extreme, argue that if a phenomenon cannot be measured, it does not exist. The goal is to continually test hypotheses and refine theory to bring us closer to the 'truth' (Mackenzie and Knipe, 2006). Establishing causality is a primary concern, and well-designed studies strive for valid and reliable insights that can be replicated and generalised to other populations and contexts (Shadish, Cook and Campbell, 2002). Constructivism, on the other hand, supports the existence of multiple realities which can be explored through an interactive participant-researcher dialogue (Charmaz, 2014; Mackenzie and Knipe, 2006). Clarke (2005) argues that reality is situationally and socially constructed; research reality will include both the researchers' and participants' perspectives. Constructivism is closely associated with qualitative research methods, and typically involves detailed and rich accounts of subjective experience (Johnson and Onwuegbuzie, 2004).

2.3   Mixed-methods research (MMR): a pragmatist solution

As quantitative and qualitative methods are often situated in different paradigms, some commentators have argued they are incompatible (Bednarz, 1985) and "incommensurable", meaning they cannot be compared or measured against each other (Sale, Lohfeld and Brazil, 2002). However, the debate over paradigms within the literature has encouraged the development of new understandings about mixing methods (Johnson and Onwuegbuzie, 2004; Shannon-Baker, 2016), including the emergence of pragmatism as a new research paradigm (Morgan, 2007).

While pragmatist researchers acknowledge the epistemological and ontological differences of paradigms, they are more concerned with effecting positive change through problem-focused research (Bishop, 2015). Morgan (2007) notes that pragmatism does not intend to present a singular worldview but seeks to find meaningful solutions to social problems. Pragmatists contend that knowledge is fluid and somewhat indeterminate, influenced by time and context (Charmaz, 2014), and theories are considered tools, not absolute truths, which are judged according to their usefulness in a given context (Bryant, 2009).

With the assumption that facts and values cannot be separated, pragmatist research often uses qualitative and quantitative methods together to deepen understanding of what works in practice (Morgan, 2007). The combination of methods is intended to provide greater understanding of the area under investigation than if each were used in isolation (Creswell and Plano Clark, 2011); this is a key benefit cited for employing mixed-methods research (MMR), especially in matters related to public health where a comprehensive understanding of social functioning is required (Kaur, 2016). Accordingly, Greene (2007) encourages researchers to direct attention away from incommensurable attributes of paradigms (e.g. objectivism-subjectivism) and instead focus on different but not fundamentally incompatible attributes (e.g. outsider-insider view, the representative and the unusual, generality-particularity); this allows researchers to embrace diversity and "get on to the work of applied social inquiry" (p.53-4).

With a similar attitude, several addiction scholars have called for increased use of MMR, e.g. (McKeganey, 1995; Neale, Allen and Coombes, 2005; Neale and Strang, 2015; Rhodes *et al.*, 2010). McKeganey (1995) suggests the divide between qualitative and quantitative research in the field of addiction is "unhelpful" because, he argues, a multi-factorial approach is required to understand the complex relationships between environmental, social, and psychological influences on behaviour (p.749). His conclusion that a desire for greater understanding of the field should take precedence over philosophical disputes of the past, echoes the position taken in this thesis.

2.4   Pragmatism and grounded theory

Grounded theory methodology complements a pragmatist approach given the shared focus on understanding process and change (Bryant, 2009; Charmaz, 2014). Glaser and Strauss (1967) introduced grounded theory as an approach for generating new theory from data, in contrast to hypothesis-testing research. The methodology stems from symbolic interactionism, which itself has pragmatist underpinnings, and is concerned with understanding the meanings that people impose on objects, behaviours, and others, through which they interpret their social world (Blumer, 1969). Subjective interpretations are thought to determine behaviour and identities, and this is what a grounded theory study seeks to understand. It is well suited to under-studied and under-theorised areas of research and is helpful for making sense of both similar and contrasting participant accounts (Burck, 2005).

Grounded theory advocates a recursive and iterative approach to research which encompasses not only analysis, but also data collection, participant selection, and theory development. A central tenet of the method is constant comparison of "incident to incident, incident to codes, codes to codes, codes to categories, and categories to categories" (Birks and Mills, 2011, p.11); a fully integrated grounded theory is achieved in part through this constant comparative analysis. In the context of a multi-study MMR project, later studies will be informed by (and are indeed dependent on) earlier studies. This continual development and adjustment in response to feedback aligns with the pragmatist position; ongoing analysis seeks to understand how tentative theoretical concepts "actually *work*" in elucidating specific research contexts and are retained if they prove themselves to be useful (Bryant, 2009).

Various versions of grounded theory have evolved, e.g. (Corbin and Strauss, 1990; Glaser and Strauss, 1967; Strauss and Corbin, 1990), but I took a constructivist stance (Charmaz, 2014) in my research. I see it as an impossibility to adhere to Glaser and Strauss' (1967) requirement of approaching a new project without any preconceptions or hypotheses. As Charmaz, amongst others, has argued, the researcher brings with them a host of experiences and knowledge, including awareness of the literature, that cannot be simply disregarded. Prior to PhD study, I was employed as a substance misuse recovery worker in a specialist community treatment service. This role involved completing comprehensive assessments of need, delivering one-to-one psychosocial interventions, and facilitating group-based therapy. I also have experience of growing up with a family member who was alcohol dependent. My understanding of some of the difficulties faced by individuals and their families who have problems with alcohol undoubtedly impacted on my approach to the research. Maintaining reflexivity throughout the research process is crucial to monitor the impact of preconceptions and positions and is important to

increase rigor in a grounded theory study (Hall and Callery, 2001). I kept a reflexive research journal and wrote memos during each study for this purpose.

A constructivist approach was also chosen because it holds the possibility of multiple realities – the researcher's role is to make sense of these, construct a mutual reality and "see it from the inside" (Charmaz, 2011, p.366). Constructivist grounded theorists reject the notion of 'discovery' as discussed in earlier versions of the method; theory does not 'emerge' from the data itself, as Glaser and Strauss (1967) contend, but rather, is constructed through the dynamic participant-researcher relationship. It is therefore plausible, and likely, for different researchers to develop different theories from the same dataset (Greckhamer and Koro-Ljungberg, 2005). This aligns with the pragmatist position that "there are no fixed points from which reality can be observed" (Bryant, 2009, p.21).

Several authors, including the initial exponents, support the use of both qualitative and quantitative data in developing grounded theories (Glaser and Strauss, 1967; Johnson, McGowan and Turner, 2010). Johnson et al. (2010) suggest a mixed-methods grounded theory (MM-GT) study is particularly useful for fusing idiographic understandings of reality (typically garnered through qualitative methods) with nomothetic insights (via quantitative methods) ; it can unite macro theories with micro experiences (Mason, 2006). MM-GT seeks to answer complex, process-orientated questions: what works, how does it work, for whom and in what situations? Guided by pragmatist philosophy, this approach therefore seemed well suited to answer questions about the complex and multifaceted nature of living with and beyond problematic alcohol use.

Chapter 3 provides a thorough description of the specific grounded theory steps for data collection and analysis used throughout this thesis so this is not included here. However, it is important to state that these core grounded theory principles were used throughout all stages of the research process. Thus, although this thesis comprises several separate studies asking different questions (see Section 2.5), an overarching methodology connects them. The questions raised in Study 1 informed the development of Study 2 and so on; each study enhanced theoretical understanding of the area under investigation, and new findings required re-examination of earlier findings (this included qualitative data prompting additional post-hoc quantitative analyses). A pragmatist philosophy guided the research agenda of developing a shared understanding of participants' experiences of problematic alcohol use in the hope my theoretical insights might apply in practice to other populations and contexts (a process Morgan (2007) terms "transferability").

2.5   Summary of studies

Classic texts (Campbell and Fiske, 1959; Denzin, 1970; Jick, 1979) describe the process of 'triangulation' which refers to researchers using multiple methods to investigate one underlying question in an attempt to validate the results; it is assumed that one can be more confident in conclusions if different methods lead to the same result. However, triangulation in this sense reduces the utility of MMR to answering *one* question from multiple perspectives – and this is not the primary purpose of this thesis (although in the event, some findings did triangulate others). Instead, this thesis involves two studies undertaken in three separate phases (described below), each asking different questions that required the use of different methods, but from which the findings could be integrated to provide greater understanding of living with and beyond a problematic relationship with alcohol. The overarching aims of this thesis, which connect the separate strands of research were to:

1) **gain an in-depth understanding of how those with a range of drinking patterns and treatment experiences, whose narratives are largely absent in the literature, conceptualise their relationship with alcohol**

2) **generate theory about processes and determinants of recovery**

To address these aims, the following studies were conducted:

STUDY 1: *Semi-structured in-depth telephone interviews with members and browsers of 'Soberistas'*, an online mutual aid group for individuals wanting to address their problematic alcohol consumption. Interviews aimed to gather in-depth qualitative data about experiences of recovery in a largely non-treatment seeking population. Use of online support to address problematic drinking is under-researched, so an exploratory design was needed to identify key factors influencing recovery in this 'hidden' population who often desire anonymity and fall outside the radar of professional services (see page 49, Chapter 4, for the specific research questions guiding this study). Interview data were analysed in accordance with constructivist grounded theory principles (see Chapter 3). This first study generated initial ideas about the role of identity processes in addiction and recovery. Specific methodological details and results are presented in Chapter 4.

STUDY 2: *Mixed-methods observational cohort study of patients with alcohol use disorders (AUD) presenting to Southampton General Hospital*

Study 1 (*Soberistas*) was a cross-sectional study, limiting what could be understood of participant recovery journeys to a single interview. Moreover, having recruited from one mutual aid group,

participants' conceptualisations of alcohol and recovery were relatively homogeneous, in keeping with the *Soberistas* philosophy. A six-month follow-up hospital cohort study, with liberal inclusion criteria, was therefore designed to harness greater understanding of a more diverse sample of participants and their relationship with alcohol over time (see Page 85, Chapter 5, for specific research questions). While most general hospital patients with AUD are not in specialist alcohol treatment (Bertholet *et al.*, 2010; Freyer *et al.*, 2007; Owens *et al.*, 2016; Parkman *et al.*, 2017b; Rumpf, Hapke and John, 1998), their use of secondary care services and assessment by clinical staff, brings to the fore their problematic alcohol use, and the option of secrecy is removed. This contrasts with the experiences of *Soberistas* participants, many of whom never spoke of their problematic drinking, and provided an opportunity to explore identity and change processes in a different population. A longitudinal observational study was conducted and comprised two phases:

- **PHASE I:** *Structured quantitative interviews* were conducted with patients during an unscheduled hospital attendance/admission, and again six-months later. The aim was to gain reliable and valid estimates of participants' alcohol use and related measures (e.g. psychological dependence and readiness to change) in a standardised format, and assess the change (or lack thereof) in the following months. Data from this investigation provided a framework for exploring participants' experiences in-depth (Phase II below) by contextualising their qualitative narratives and enabling purposive selection of individuals to interview. Chapter 5 describes the specific procedural steps taken in this study, including statistical analyses, and results are presented in Chapter 6.

- **PHASE II:** *Semi-structured in-depth face-to-face interviews* were conducted with a sub-sample of participants who completed both interviews in Phase I. As per grounded theory principles, the approach to this study was iterative and continued to test the constructs identified in earlier studies (e.g. identity processes), in addition to exploring new avenues (e.g. the impact of a hospital attendance/admission on participants' relationship with alcohol). In-depth qualitative interviewing techniques were employed to elicit detailed accounts from participants; quantitative data collected during Phase I enabled purposive selection of a diverse sample of participants, whose experiences were most likely to enhance theoretical understanding. I also drew on analysis of quantitative data collected during baseline and six-month follow-up to stimulate discussion around areas of interest, with the aid of a graphic task (Wouters *et al.*, 2008). Chapter 5 describes the specific procedural steps taken in this

study. Data were analysed according to constructivist grounded theory principles (Chapter 3), and results are presented in Chapters 7-9.

2.5.1   An integrative understanding

Figure 2, shown on Page 31, presents a visual illustration of the MM-GT design used in this thesis and highlights the relationship between each study. Many so-called mixed-methods studies fail to integrate qualitative and quantitative arms (Bryman, 2007). Although studies in this thesis were conducted sequentially, the methodology is integrative, evident in the following ways:

a) Sampling and research development

Early studies informed the decision about how subsequent phases of the research should progress, as well as the selection of participants themselves. For example, the decision to recruit a clinical population (i.e. physically unwell hospital attendees) followed from Study 1 with *Soberistas* members and browsers who comprise an entirely different sample in terms of demographics, use of services etc. This accords with grounded theory principles of purposeful sampling to achieve a maximum variation of characteristics expected to influence understanding of evolving theory. The focus of the Phase II hospital study, and the participants recruited, stemmed from integration of the first two studies.

b) Analysis and interpretation

As per grounded theory methodology, data from each study were compared and contrasted throughout the whole research process to generate a more comprehensive understanding of participants' experiences. Areas of agreement, inconsistencies and contradictions were explored in written memos to highlight how the data from each study told similar or different stories about the area under investigation. Visual maps were drawn throughout the project which included findings (quantitative and qualitative) from across the studies; this provided a helpful framework for data integration and reflected conscious decisions to amalgamate findings. Additional data from the literature were also incorporated throughout analysis to encourage "innovative insights" and aid interpretation of my data (Bryant, 2009, p.21).

In addition to planned statistical analyses, qualitative findings prompted some additional exploratory post-hoc analyses of quantitative data, including a secondary regression analysis (Section 6.5 in Chapter 6) and group comparisons (e.g. Section 8.2.3 in Chapter 8). While post-hoc

findings must be interpreted with caution (Field, 2009), they assist in a grounded theory exploration of participant experiences and provide data for future testing.

c) Write-up

For clarity, studies are presented in the order they were conducted. However, a strong narrative thread runs throughout the thesis, with subsequent chapters building upon those that came before. Findings from earlier studies and other literature are brought into results chapters to tell a story of how, in collaboration with participants, I developed theoretical insights about life with and beyond problematic alcohol use. The discussion chapter (Chapter 10) seeks to integrate findings from all studies and suggest implications for clinical practice and future research.
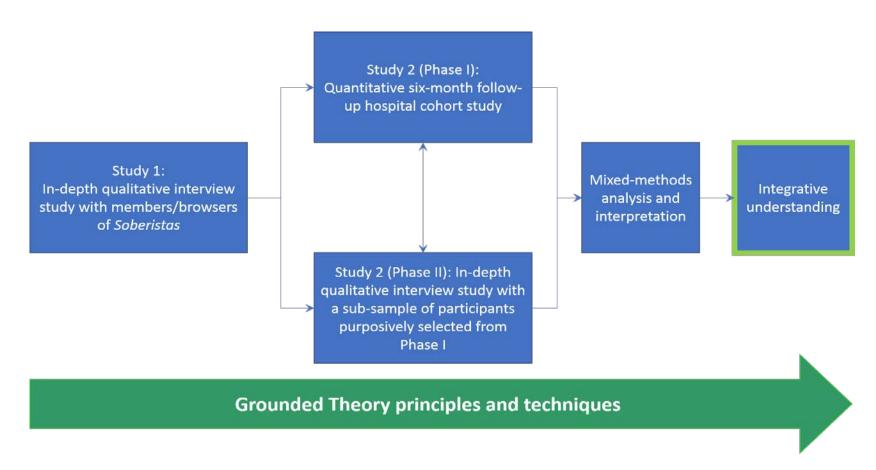
Figure 2:   The mixed-methods grounded theory design employed in this thesis

2.6   Summary

This chapter provided an overview of the research approach taken in this thesis to enhance understanding about living with and beyond a problematic relationship with alcohol, from the perspectives of individuals whose stories are largely absent in the literature. A MM-GT approach, underpinned by pragmatism, allowed for a shift from simply *measuring* problematic alcohol use and recovery outcomes, to investigating them as meaningful personal and social experiences. Thus, this thesis aims to integrate findings from the studies described above and position them within the wider literature to hypothesise about psychosocial mechanisms (including identity processes) that might underpin change.

Chapter 3   CONSTRUCTIVIST GROUNDED THEORY METHODOLOGY

3.1   Introduction

This chapter provides an overview of key grounded theory principles that were employed during the collection and analysis of all qualitative data presented within this thesis; specific methodological details pertaining to each study can be found in their corresponding chapters. The use of first person throughout this chapter (and others) is intended to highlight the subjectivity inherent in qualitative research and is consistent with a constructivist approach to grounded theory (Charmaz, 2014). It is important to be transparent about the decisions I made throughout the process and discuss personal biases that could influence my interpretation of the data. While grounded theory analysis is recognised as complicated and "messy" (Munhall, 2012, p.238), I aim to provide a clear account of the steps I took at each stage. I followed the structure proposed by Tweed and Charmaz (2012, p.133):

1. Development of the research question
2. Sampling and recruitment of participants
3. Data collection
4. Initial coding
5. Focused coding and categorisation
6. Theory building
7. Write-up

Figure 3 on Page 34 depicts this process diagrammatically.

Methodological features, including memo-writing, constant comparisons, and theoretical sampling, are intrinsic aspects of grounded theory research, and will be described as part of the analytic process later in the chapter.
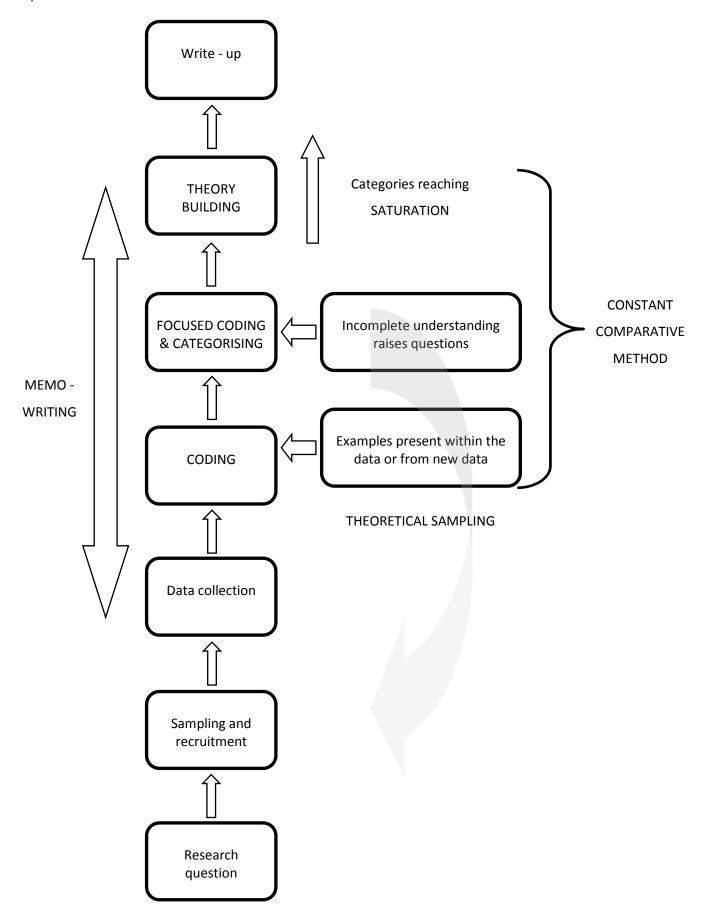
Figure 3:   The grounded theory process, adapted from Tweed and Charmaz (2012, p.133)

3.2 Research team and reflexivity

Charmaz (2004, p.991) advises researchers to choose topics that ignite their passion. My passion for conducting addiction-focused research stems from familial experience of addiction and subsequent work in the field. These experiences inevitably had an impact on my research; my knowledge, personal history, training, and thoughts/feelings about the topic area, shaped my approach to interviewing and construction of reality with participants. I feel my prior knowledge and experience facilitated effective dialogue with participants and helped build rapport; although I kept discussion of my personal experiences to an absolute minimum, participants could probably sense I had some understanding of the challenges associated with problematic drinking. I kept a journal throughout the research process to log my thoughts and feelings about the study as it evolved and discussed any areas of difficulty with my supervisors. Some of my reflections arising throughout the study are incorporated into the following sections to highlight my 'active' role as researcher.

I received specific training in advance of the first study (Chapter 4) by Dr Krysia Canvin, who is an expert in qualitative methodologies, specifically grounded theory. Dr Canvin also provided supervision throughout all stages of the *Soberistas* project, alongside my PhD supervisors, Professor Julia Sinclair and Professor David Baldwin.

3.3 Data collection

3.3.1 Constructivist Interviewing

During interview, participants were asked to talk freely about their relationship with alcohol, treatment history, and any other relevant experiences, as a way of understanding their journeys of addiction and recovery. Participants were in control of the length of interview and consequently there was quite a range in duration (19-121 minutes for the *Soberistas* study and 40-181 minutes for the hospital study). Topic guides (Appendices A and B) ensured I covered all essential areas of interest, but participants were encouraged to 'take the lead' and remain at the centre of interviews. Open-ended interviewing techniques facilitated this (e.g. probing, exploring issues raised by the participant, asking for clarification or specific examples where necessary). A graphic task (Wouters *et al.*, 2008) was used during face-to-face interviews with hospital participants, as they are shown to help elicit discussion related to complex events, ideas, experiences, or emotions (Copeland and Agosto, 2012; Crilly, Blackwell and Clarkson, 2006); see Chapter 5 for further details. Moreover, visual mapping techniques are often used during alcohol

treatment to help build rapport, reduce anxiety for those less comfortable with eye contact, facilitate communication, and maintain focus, e.g. (PHE, 2013b).

As alluded to earlier (see Section 3.2), the researcher's ability to appropriately draw on prior knowledge and experience is considered essential in grounded theory to construct quality data. A skilled interviewer focuses on relationship building, the flow of conversation, their professional and theoretical position, and exploits their use of self to communicate with participants and create narrative (Nunkoosing, 2005). In constructivist interviewing, the interviewer takes an active role in understanding the worlds of participants through collaborative dialogue. Charmaz (2004) also advocates temporarily abandoning one's role as researcher if it is appropriate to validate participants' experiences – she says, "respect for research participants as persons supersedes research objectives" (p.985). Therefore, a sensitive and empathetic approach to interviewing was crucial. This included the decision to change focus if I sensed a participant was not comfortable. The following example is taken from an interview during Study 1:

> *Interviewer: **Does your family know [about Soberistas]?***
>
> *Participant: I have a wife and well a son who still lives at home.*
>
> *Interviewer: **And do they know you use the site?***
>
> *Participant: Er no. No, they don't. No, they don't [long pause].*
>
> *Interviewer: **Is there any reason why?***
>
> *Participant: They just don't.*
>
> *Interviewer: **Ok. So, say someone had never heard of Soberistas before – didn't have a clue what you were talking about – how would you describe it to them?***
>
> <div align="right">*Excerpt from Study 1 interview with 'Kevin'*</div>

After this interview, I attached a memo to this section of dialogue which read:

> *I sensed 'Kevin' did not want to continue with this area of questioning – this bluntness contrasted with his style of communication during the rest of the interview, and so I decided to change focus to a less sensitive topic.*

During the hospital study, there were several occasions where participants presented to interview or contacted me via telephone, during episodes of intoxication, acute distress, or suicidal crisis. Again, individuals' wellbeing took absolute precedence, and appropriate steps were taken to ensure their safety, within the bounds of research good clinical practice (e.g. offering compassionate and non-judgemental support, seeking clinical supervision, liaising with professional, including emergency, services).

3.3.2   The interview process

Establishing rapport prior to interview was important for me to feel comfortable asking, and participants to feel comfortable answering, personal questions. This was easier with individuals participating in the hospital cohort study as I had met them twice prior to qualitative interview. For *Soberistas* participants, an introductory telephone call alleviated any concerns participants had and helped develop rapport. Also, on reflection, the use of telephone interviews added another layer of comfort and reassurance for participants. Although some have argued that telephone interviews are only suitable for short, structured interviews, e.g. (Fontana and Frey, 1994), there is little evidence that they produce less-quality data than face-to-face interviews (Novick, 2008).

Overall, interviewees gave detailed and rich accounts of their experiences, and many disclosed sensitive personal information relating to their use of alcohol, relationship problems, health concerns, and difficulties at home/work. Many participants commented on the interview being a positive experience and were grateful for the opportunity to tell their story, sometimes for the first time. For example:

"I enjoyed talking to you about my recovery, in retrospect it was therapeutic and made me realise how far I have come, so thanks."	Email from 'Caroline' (Soberistas participant)
"It was a pleasure, you made it easy, thank you."	Email from 'Amanda' (Soberistas participant)
"Thank you, Sophia. It's an issue close to my heart and I am very happy to have had the opportunity to talk to you about it."	Email from 'Phil' (Soberistas participant)
"I'm glad it's helped you and might help other people. I have had help, so I am quite happy, you do whatever you want with it."	Comment from 'Donna' (Hospital participant)
"Anything else you need I am here. You have actually helped me Sophia, a lot. Good luck with your work."	Comment from 'Daniel' (Hospital participant)
"Thank you for letting me take part in this. Being able to talk and being asked questions…by talking it through you get more understanding of it yourself."	Comment from 'Lorna' (Hospital participant)

3.3.3   Data management

I audio-recorded and transcribed interviews verbatim, usually within a few days. The qualitative software package NVivo (v.11) was employed to aid storage, retrieval, and systematic coding of the dataset. Transcribing every interview allowed for familiarisation with, and deeper understanding of, the data. It also provided opportunity to reflect on and refine interviewing techniques (e.g. avoiding closed questioning).

A decision was made to not routinely send transcripts for participant comments or corrections. The main reason being that it was unlikely all participants would have provided comments or corrections, and therefore interviews with corrections would be different in nature to those without – corrected transcripts would change from participants' 'talk' to reflections *on* their talk. Other reasons included practicalities and safeguarding. I was often unaware of participant addresses/identities in the *Soberistas* study; as many individuals discussed highly sensitive personal information which occasionally caused them to become upset during interview, it seemed unhelpful to send transcripts which could potentially exacerbate this. In the event, no *Soberistas* participant requested a copy. A few individuals participating in the hospital study requested, and were sent, transcripts to keep for their own record, following discussion with supervisors.

3.3.4   Literature as data

One of the major areas of contention in a grounded theory study is the use of literature. Chapter 1 presented and justified the limited, and purposive, preliminary literature review, most of which was conducted prior to data collection, and helped me orientate the field of study (Urquhart, 2007). However, literature plays a key role at all stages of a grounded theory study and is used differently than in other forms of research. Here, literature is considered a *source of data* and must be drawn upon throughout analysis (Charmaz, 2014). I sourced literature when theoretical questions arose during the project, which in turn informed my decision about new avenues to explore and further questions to ask. My use of literature increased as the research progressed. While my early review (Chapter 1) highlighted key concepts and theories important for understanding recovery from problematic alcohol use generally, subsequent literature searches focused on studies investigating self and identity processes specifically. I did not initially intend to delve into this area, but it became necessary because of the way in which *Soberistas* participants described their recovery in relation to engagement with online mutual aid. Further data collection during later studies with participants recruited in hospital required exploration of new literature. To reflect this evolving process, literature is woven into results chapters where it enhances or

clarifies understanding of the findings being presented. Supporting and contrasting literature are used to contextualise and compare my findings and are viewed as another 'voice' that contributed to theorising.

For me, one of the biggest attractions of constructivist grounded theory methodology was this flexibility to use literature in a way not adopted by other approaches; this resulted in exciting exploration of unexpected literature, and ultimately, better understanding of participant experiences by positioning findings within the context of current knowledge. Broad reading was supplemented by more thorough search strategies for literature relating to concepts particularly relevant to participants' experiences. For example, with the concept of 'identity', I searched databases (MEDLINE, EMBASE, and PsycINFO) using keywords including: alcohol*, addict*, recover*, identi*, self, self-concept, self-schema, label*, self-efficacy, self-evaluation, self-perception, and diagnos* (where * indicates truncation, allowing for different permutations of the terms). I also screened relevant reference lists and books. Whilst this approach is comprehensive, it was not intended to be fully systematic whereby all papers relating to the topic area were included. Rather, papers were selected for their relevance and pertinence, and if their content contributed to theoretical understanding of participants' experiences.

3.4 Data analysis

Analysis in grounded theory research is complex and hard to put into words; is iterative and non-linear, and continues through to the final stages of write-up. The researcher approaches data collection, analysis, and theory development simultaneously. This section aims to provide a transparent account of the methods used to analyse data presented within this thesis, informed by Tweed and Charmaz's (2012) approach, depicted in Figure 3 earlier. While these steps are most directly relevant to analysis of qualitative interview data, it is important to note that quantitative data collected during the hospital cohort study (Chapter 6) were incorporated into the analytic process, in keeping with a mixed-methods approach.

3.4.1 Initial coding

The first stage of analysis involved open line-by-line coding of interview transcripts which was performed as data were collected. This encouraged familiarisation and prompted the start of data categorisation. Line-by-line coding promotes close affinity with the data and ensured that I analysed data 'from the ground up', keeping the authenticity of participants' accounts. Appendix C provides an example of line-by-line coding of part of an interview transcript.

Charmaz (2014) suggests using gerunds in initial coding to reflect action and process and to retain the dynamic nature of participants' accounts. 'In vivo' codes take the words of participants directly and were also used during this phase of coding. Use of gerunds and in vivo codes preserved the language participants used and the meanings they ascribed to their experiences. They also reduced the possibility of projecting any preconceived ideas onto the data and ultimately generating theory which reflects my perspective rather than that of participants.

"Turning point" is an example of an in vivo code which uses a gerund. This initial code reflects the moment participants decided to give up drinking alcohol, which sometimes coincided with a particular event (e.g. the death of a loved one or admission to hospital). *"Losing control"* is another code that captured part of participants' experience of addiction. This code represents a complex process that occurred over time and was therefore best expressed as a gerund; the codes "no control" or "lost control" would have reduced this process to a simple topic (Charmaz, 2014, p.120). Using gerunds for initial codes allowed me to make connections between data and other codes more easily during later stages of coding; I could gain a handle on larger portions of data as I was coding processes that were common to several participants (Tweed and Charmaz, 2012).

3.4.2 Focused coding and categorisation

Focused coding involved taking the most useful and frequent codes identified in the initial coding phase and applying these to larger chunks of data (Charmaz, 2014). This stage of coding therefore required a more concentrated and selective approach to analysis. During focused coding, I compared codes as represented by different participants to refine my understanding of them. For example, with the code *"affecting the body"* (Chapter 7), I looked to see how different participants described and defined bodily changes because of their alcohol use, to clarify what this experience entailed; I asked questions of the data about the nature of these changes, when changes occurred, why some individuals noticed changes and others did not, and the implications of bodily changes. This analysis brought the initial "affecting the body" code up to the category, *"the embodiment of alcohol use"* which recognised corporeal changes as being integrally linked to participants' sense of identity.

Categories "explicate ideas, events or processes in the data" (Charmaz, 2014, p.189) – they move beyond simple description. Categories are the accumulation of continuing analysis of data, and often change as the theory develops. For example, *"abstaining from alcohol"* (an initial code during analysis of *Soberistas* interview data) was later reconceptualised into two separate but related categories – *"becoming alcohol-free"* and *"being secure in sobriety"*. The former

represents the physical state of achieving abstinence but incorporates the term *"alcohol-free",* a phrase of significant meaning to members of *Soberistas*. The latter represents a state of mind that participants described arriving at after a period of being *"alcohol-free"*. Thus, whilst one is dependent on the other, they reflect distinct processes that the initial code *"abstaining from alcohol"* failed to capture.

3.4.3   Memo-writing

Memos are the cornerstone of grounded theory analysis. They "catch your thoughts, capture the comparisons and connections you make, and crystallise questions and directions for you to pursue" (Charmaz, 2014, p.162). They served as a diary of evolving thoughts and feelings about the data and the thesis as a whole. I wrote memos about impressions of interviews, codes, emerging categories, and the theoretical and conceptual framework which led to the generation of theory. Write-up would not have been possible without reliance on memos written throughout the project as they served as a coherent story linking the various strands of data (within and across studies) together. I include examples of memos throughout my results sections to illustrate their use.

3.4.4   The constant comparative method

The constant comparative method is another key analytic technique employed in grounded theory and is also used at every stage of analysis (Glaser and Strauss, 1967). The method requires the researcher to make comparisons between data (e.g. interview cf. interview, code cf. code, quantitative cf. qualitative) to identify similarities and differences. As this is repeated at all stages of analysis, categories continuously evolve. Essentially, this process serves as verification and validation of emerging conceptualisations – it ensures that categories are supported by the data being collected (Holton, 2007).

Moreover, this technique forced me to challenge my preconceptions. For example, one interesting avenue of analysis that gripped me early on was understanding how participants labelled, or 'diagnosed' their problematic drinking. Having worked in treatment services and been familiar with the DSM-5 conceptualisation of 'alcohol use disorder' as a single disorder incorporating increasing levels of risk, I viewed problematic drinking as situated on a continuum. However, this view was not necessarily shared by participants who were generally less familiar with diagnostic criteria. *Soberistas* participants, for example, tended to uphold a categorical definition of diagnosis (i.e. "drinker" vs. "alcohol-free"). Memos allowed me to keep track of how different participants described their problematic drinking and why this may differ from my

understanding. The notion of labelling and self-concepts in relation to alcohol use became a key interest throughout all studies in this thesis.

The constant comparative method also plays an important role in mixed-methods grounded theory research (Johnson, McGowan and Turner, 2010). In the hospital cohort study, quantitative and qualitative data were collected and analysed concurrently; both types of data informed interpretation and testing of the other. For example, analysis of qualitative narratives suggested that psychological dependence was more important than actual consumption in shaping participants' conceptualisations of their relationship with alcohol (Chapter 7). This finding prompted a secondary, exploratory regression analysis to determine which factors predicted clinically significant and reliable change in psychological dependence as measured by the 'Leeds Dependence Questionnaire' (Chapter 6); the results of this analysis then guided further exploration of qualitative data. To provide another example, quantitative and qualitative data were compared/contrasted to gain greater understanding of participants' experience of having their alcohol use assessed in a hospital setting. Quantitative ratings suggested participants generally found their assessment to be a positive experience, and regression analyses identified the significance of a first-ever assessment of alcohol use in a hospital setting for favourable drinking outcomes six months later. Qualitative narratives were analysed to understand why individuals might evaluate their hospital experience as positive, and why first assessments might be associated with better outcomes (Chapter 8).

3.4.5 Theoretical sampling and saturation

"Initial sampling in grounded theory gets you started; theoretical sampling guides where you go."

(Charmaz, 2014, p.197)

Theoretical sampling is a vital grounded theory strategy which is employed to gather more data to develop the tentative categories identified during earlier stages of analysis. The properties of early categories often rely on assumptions and need further clarification. Theoretical sampling seeks to collect data that elaborates and refines these categories until no new properties emerge (i.e. categories are theoretically *saturated*). Thus, it is not used to increase generalisability or represent a population – it is used to provide a complete and comprehensive theoretical picture of categories. Theoretical saturation therefore determines sample size in a grounded theory study.

The researcher determines initial sampling which provides a starting point and raises questions. Theoretical sampling seeks to answer these questions and is therefore determined by gaps in the data. In the *Soberistas* study, participants were interviewed once, so new participants were

sampled to achieve theoretical saturation. For example, an initial category related to participants becoming more active on the site – some participants stated they contributed to blogs and discussion posts, but analysis of these early interviews raised further questions. It became necessary to understand why someone would contribute to the site, at what point they decide to contribute, and what stops people from contributing. Hospital study participants, on the other hand, were interviewed up to three times (two quantitative interviews – baseline and follow-up – and one qualitative interview). This allowed me to 'test' evolving conceptual and theoretical ideas within and across participants, drawing on both qualitative and quantitative data, at multiple stages of the study.

Creating models and visual diagrams of the various categories helped to clarify links between them and proved invaluable in the development of theory (see Appendix D for examples). Moreover, visual data collected through use of a graphic task (Wouters *et al.*, 2008) during interviews with hospital participants enhanced my understanding and analysis of qualitative narratives. Memos written throughout the project were linked to relevant aspects of the diagrams to assist with this process.

3.4.6   Negative cases

'Negative cases' are data that contradict or disagree with the major pattern represented by most of the data (Charmaz, 2014, p.198). A researcher may deliberately search for contradictions, or they may arise naturally. Negative cases need to be analysed and incorporated into the theory to strengthen it.

Negative cases can highlight that certain categories need further exploration, or they may enhance the credibility and robustness of existing categories. An example of a negative case in the *Soberistas* study came from 'Liz', the only participant who discussed an intention to moderate her alcohol consumption. *"Becoming alcohol-free"* was an important category reflecting the *Soberistas* ethos of abstinence, and Liz's experience of hostility on the site because of her decision to drink 'socially' only strengthened the case for this category. Similarly, in the hospital study, participants' narratives varied considerably during interview in terms of content and form, except for a few which appeared to be 'fixed' throughout. Further analysis of these exceptional negative cases, considered within the context of other interviews and research, highlighted the impact of recovery group engagement (e.g. 12-step fellowships) in shaping how these participants reflected on their relationship with alcohol; the few participants whose narratives were highly structured had experience of reciting their story within the context of attending groups such as Alcoholics

Anonymous. The "multiplicity" (Christensen and Elmeland, 2015) identified in the accounts of most participants became an important concern in this study.

3.4.7   Theory building

A theory tries to answer questions about when, how, and why something happens; it involves moving from specific incidents to broader statements about social processes. The constructivist approach emphasises understanding over explanation and goes further than simple description. To theorise, researchers must move beyond coding and seek to bring key categories up to concepts (Charmaz, 2014). Categories are raised to theoretical concepts when they carry analytic weight – they most fully capture what is happening in the data. Theoretical integration results in a set of logically connected concepts that together help understand crucial processes (Birks and Mills, 2011).

Uncertainty and ambiguity are to be expected when theorising. Constant interaction with the data, being open to unexpected findings, and approaching the task with "playfulness, whimsy, and wonder" (Charmaz, 2014, p.245) allowed me to scrutinise participants' experiences. Instead of striving to identify the 'basic social process' (Glaser and Strauss, 1967) or single 'core category' (Corbin and Strauss, 1990) which represents the main concern for participants, I aimed for an integrated conceptual theoretical framework that captured the complex nature of participants' worlds (Charmaz, 2014). The framework developed through interviews with *Soberistas* participants, entitled *'managing multiple facets of self'*, is the result of analytical construction of meaning, and highlights the role of various identity processes in understanding participants' experiences of recovery from problematic drinking (Chapter 4). Three key concepts (maintaining "normal" selves; addressing the alcohol 'identity'; creating an "authentic self"), together with their corresponding categories, support the theoretical framework. Elements of this framework, together with additional quantitative and qualitative data collected during the hospital cohort study, were synthesised to develop a second, more comprehensive theoretical framework entitled, *'negotiating alcohol use and self'* (Chapter 7). This analysis incorporated additional data which enhanced understanding of identity processes in addiction and recovery beyond those identified in narratives of participants using a single mutual aid group; it also considered the impact of an unscheduled hospital attendance/admission on participants' relationship with alcohol.

These frameworks represent *substantive* theories which offer an account of processes in specific, substantive areas (i.e. understandings of addiction/recovery were developed from interviews with users of *Soberistas* and hospital attendees at one general hospital). However, Lempert (2007,

p.247) notes that substantive grounded theories can be developed through ongoing analytical "abstraction and conceptual integration in a variety of contexts and groups", possibly leading to the development of a *formal* theory. This overcomes one of the major criticisms of grounded theory, namely that it produces 'low-level theories' about very specific areas with limited reach; engaging with the literature and existing theories (see Section 3.3.4) throughout the whole research process encourages the development of a theory that can be 'scaled up' and then tested in further research (Urquhart, 2007).

3.5   Summary

This chapter provided a detailed account of the data collection and analytic methods used throughout this thesis, which accord with a constructivist approach to grounded theory. Although the process was at times perplexing and iterative, the stages outlined in Tweed and Charmaz's (2012) model (Figure 3), provided some structure from which I could approach the task, and demonstrate rigour in the research.

SECTION 1: A QUALITATIVE STUDY OF A NEW FORM OF ONLINE MUTUAL AID

Chapter 4 METHOD AND RESULTS

4.1 Introduction

This chapter presents the methods and results of the first study I conducted to explore alternative conceptualisations of problematic alcohol use and recovery, from the perspectives of individuals whose stories are largely absent in the literature. An exploratory qualitative study was conducted with members and browsers of '*Soberistas',* a previously unresearched online social networking site for people concerned about their alcohol use. The site was launched in 2012 by Lucy Rocca, 18 months after she became abstinent from alcohol, and was designed to provide an alternative form of support for individuals for whom traditional services or mutual aid groups (e.g. Alcoholics Anonymous, AA) do not appeal (Rocca, 2018). The site is entirely peer-led except for limited content moderation, with the ethos described as "non-prescriptive, non-religious, and non-judgemental" (Sinclair, Chambers and Manson, 2016, p.221). At the time of qualitative interviews, it had a global membership base (including the UK, USA, and Australia) of >1800 subscription-paying members (fee: £34/year) and ~2000 active browsers (Chambers *et al.*, 2017). Subscription-paying members can create a profile, engage in discussions, post blogs, watch webinars and utilise various information resources; browsers can view most content but with restricted usage.

The qualitative study presented in this chapter extend the results of a cross-sectional survey that we conducted to describe the site's membership base, and its component parts and processes – see Accompanying Document; (Sinclair, Chambers and Manson, 2016). The online survey, and the qualitative results presented here (subsequently published as (Chambers *et al.*, 2017); see Accompanying Document), represent the first empirical study of *Soberistas.* Considering the gaps in literature, highlighted in Chapter 1, a qualitative exploratory in-depth interview study was designed to answer the following research questions:

1) What is the role and function of *Soberistas* as a new/alternative form of support for its members and browsers?
2) How do participants describe using *Soberistas* to address a problematic relationship with alcohol?

Through my analysis, a person-centred grounded theory was developed which answered these questions and is presented throughout the results section of this chapter (starting on Page 52).

4.2 Method

4.2.1 Participant selection and setting

Thirty-one in-depth telephone interviews were conducted with *Soberistas* members, ex-members and browsers between October 2015 and January 2016. Most participants were recruited via an online survey embedded within the *Soberistas* website from August to October 2015 (Sinclair, Chambers and Manson, 2016). At the end of the survey, respondents were asked to provide an email address if they were willing to take part in an in-depth telephone interview to discuss their views and experiences of using *Soberistas*. Seventy-six people gave an email address (17.6% of those who completed the survey). The University of Southampton's ethical review committee approved the study (see Appendix E).

To be considered for inclusion for interview, participants had to:

- Be over 18-years-old
- Be based in the UK
- Speak English
- Have visited *Soberistas* at least once
- Have access to a telephone

Using information provided during the survey, I purposively sampled and contacted 58 people (Appendix F shows the participant information sheet sent to potential participants). The strategy was to achieve a maximum variation of characteristics expected to influence experience of the site and included age, gender, current levels of alcohol use, previous treatment history and length of time with *Soberistas*. Of the 58, two replied to say they would not like to take part, three agreed to interview but subsequently withdrew consent, two email addresses were invalid and 23 did not respond.

To address gaps in my sample, I placed an advert on *Soberistas.com* in December 2015 specifically inviting males, people new to *Soberistas,* or people thinking of leaving, to participate in interview. Six people responded, three of which did not meet study inclusion criteria as they were based outside the UK. Of those interviewed, 28 were recruited via the survey and three via the advert (see Section 4.3 for details of participant characteristics).

4.2.2 Data collection and analysis

Prior to interview, participants were offered an introductory telephone call, so I could explain the study in more detail, including the consenting procedure, and answer any questions following

receipt of the information sheet. All participants accepted this initial call, and none declined to participate following this. It was during this call that participants were reminded that the interview would be audio-recorded to enable transcription. All participants then provided verbal informed consent (audio-recorded) prior to the interview starting.

During interview, participants were asked to talk freely about their relationship with alcohol, treatment history, and their views, experience, and use of *Soberistas,* as a way of understanding their recovery journeys. A topic guide (Appendix A) ensured I covered all essential areas of interest, but the participant was encouraged to 'take the lead' and remain at the centre of the interview. Participants were offered a £10 Amazon e-voucher for their contribution.

Interviews were analysed using constructivist grounded theory principles (see Chapter 3 for a detailed overview).

4.3   Participant characteristics

Table 2 displays a summary of participant characteristics (see Appendix G for a detailed overview). The final sample comprised current subscription-paying members, ex-members, and browsers. Some participants had only found *Soberistas* a few weeks prior to interview, while others had been aware of the site since its launch in 2012. Of those alcohol-free at time of interview, length of sobriety ranged from two weeks to five years. Most were positive about *Soberistas* and viewed it as a source of support and information.

Just under 42% (n=13) of the sample reported having never accessed any other form of support for drinking before *Soberistas*, and of the same number who had, only five continued to do so – for the remaining 13, *Soberistas* was now their sole source of support. Examples of other forms of treatment/support included: inpatient rehabilitation, community treatment services, AA, alternative therapies (e.g. hypnotherapy, herbal remedies) and private counselling or therapy. It is important to highlight that most the sample were female. While this is not surprising given that *Soberistas* is aimed primarily at women (Sinclair, Chambers and Manson, 2016), it was not the aim of this analysis to assess the role of gender in use of the site. Instead, I purposively sampled male members to gain a deeper understanding about use of *Soberistas* from the perspectives of the range of people who might use it for support with problematic alcohol consumption.

Table 2:   *Soberistas* participant characteristics

Characteristic	Participants n (%)
Gender	
Female	25 (80.6)
Male	6 (19.4)
Age	
25 – 34	2 (6.5)
35 – 44	7 (22.6)
45 – 54	8 (25.8)
55 – 64	10 (32.3)
65+	4 (12.9)
Membership status	
Subscription-paying member	24 (77.4)
Ex-member	4 (12.9)
Browser (non-member)	3 (9.7)
Estimated length of time on the site	
< 1 month	2 (6.5)
1 – 3 months	3 (9.7)
3 – 12 months	10 (32.3)
> 12 months	16 (51.6)
Drinking Status	
Currently drinking	7 (22.6)
Alcohol-free ≤ 1 year	12 (38.7)
Alcohol-free > 1 year	12 (38.7)
Treatment / Support (other than Soberistas)	
None	13 (41.9)
Previous	13 (41.9)
Current	5 (16.1)

4.4   Results: The theoretical framework

Meaning was constructed from the analysis to develop a theoretical framework of how participants addressed their problematic alcohol use through engagement with an online mutual aid group. Figure 4 presents the framework, *'managing multiple facets of self'*, which highlights how participants carefully constructed and reconstructed various identities to support recovery. The framework comprises three main concepts, and each will be discussed in turn:

1) Maintaining "normal" selves
2) Addressing the alcohol 'identity'
3) Creating an "authentic self"

Collectively, participants described a complex and circuitous journey of recovery. However, for ease of interpretation, the results below present a linear pathway of recovery (from problematic drinking to sobriety) and highlight how participants engaged with *Soberistas* during different stages. In keeping with grounded theory methodology, relevant literature is woven into the findings as an additional source of data (see Section 3.3.4 in Chapter 3).

Participant quotations demonstrate how interpretations are grounded in the data, with identifier format as: gender-specific pseudonym, membership status, drinking status.
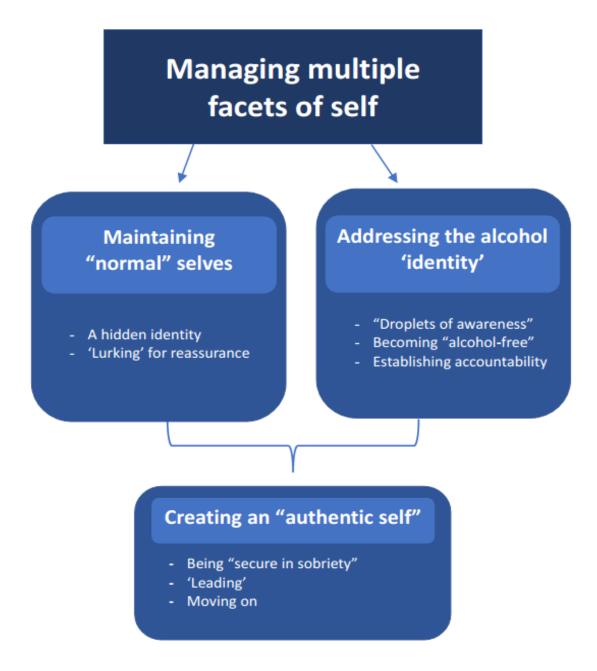
Figure 4:   "Managing multiple facets of self": a theoretical framework of how engagement with online mutual aid can support recovery

4.5   Maintaining "normal" selves

This concept concerns participants' anxiety to maintain an outward impression of what Dave described as a *"perfectly normal and functioning member of society"* (Member, 1-year alcohol-free). Almost all participants were in stable employment, with many holding positions of responsibility, including senior management roles. The majority reported having a *"normal*

upbringing" (Amanda, Member, currently drinking) with largely uneventful lives; although some participants reported traumatic experiences including sexual assault and domestic violence, they were in the minority. When asked to introduce themselves at the start of interview, almost every participant referred to their career, their marital status, their children, where they lived, and/or their age; many also included descriptions of their personality or self-concept (e.g. *"I'm quite a stressy kind person", "I am physically fit", "I am a perfectionist...one of the pleasers in life"*). Only a minority started with a description of the role alcohol played in their life, despite knowing this was the focus of the interview.

Tracy and Trethewey's (2005) 'crystallised self' theory, like Goffman's (1959) dramaturgical perspective, conceptualises identity as multi-dimensional, fluid and context-dependent: there is no 'fake' nor 'real' self, just different aspects of the whole. Data within this concept support a multi-dimensional view of identity; participants often spoke of occupying numerous identities, of which a 'hidden drinking identity' was just one. The categories, 'a hidden identity' and 'lurking for reassurance' explain how participants managed their problematic drinking identity alongside their *'normal and functioning'* identities, and how engagement with *Soberistas* supported this.

4.5.1   A hidden identity

Many participants described the secrecy that surrounded their drinking behaviour which often resulted in them feeling *"isolated", "trapped"* or *"lost".* Sarah (Member, 3-months alcohol-free) explained:

> *"I had this hidden secret that I was a drinker. I presented myself to the world as efficient, a coper...there's the pride, the secretiveness of it, you're presenting one side, but in actual reality, that's not what you're really like."*

Sarah later revealed she worked at a local general practice (GP) surgery and refused to disclose concerns about her alcohol consumption to a doctor there because she *"would have felt a sense of shame"*. Others feared the repercussions of disclosing unhealthy alcohol use to a health professional because *"it would stay on my medical record"* and may jeopardise employment, or risk *"social services getting involved"* if the person had children. Many also cited *"embarrassment"* and *"the huge stigma in and around excessive drinking"* (Michelle, member, 5-months alcohol-free) as reasons for not seeking help.

Commonly, participants described how their problematic drinking was kept totally hidden to protect relationships, career, pride, or self-image. Some even claimed close family and friends were unaware, for example;

> *"I don't think any of my close friends or family would have any idea that I was kind of having a struggle with the way I was drinking – and I don't know that I would particularly want them to know."* (Kimberley, member, 2-months alcohol-free).

> *"I have kept it quiet. It's a closed thing for sure. Managing it [his drinking] has been an issue. It has to be managed."* (Paul, member, currently drinking).

> *"None of them know, no. None of them know anything. I have been married for 35 years so I think my wife would be a bit surprised I hadn't discussed it."* (Ben, member, 3-years alcohol-free).

Some explained they attempted to share their concerns with family and close friends, but were dismissed; Maria (ex-member, 2-years alcohol-free) said, *"My mother and husband would say – 'you don't have a drink problem, don't be so silly'. Nobody thinks I had a problem."* This experience was quite typical amongst participants, and it seemed that the ability to function 'normally' prevented others from taking participants' concerns about drinking seriously.

Although originally used to describe migration experiences, Park's (1928) notion of the 'marginal man', as someone living in two different cultures but not fully integrated into either, can be applied to experiences of any person living on the periphery of multiple 'worlds' (Anderson and Levy, 2003). Participants in the present study appeared to find themselves in this position, juggling their identity as *"a drinker"*, as well as maintaining their identity within their family and wider society. Anderson and Levy (2003) describe marginality in people considered 'deviants' in society (a label often attributed to someone with an addiction) which highlights the conflict arising through occupying multiple identities:

> "Deviants' are rarely fully deviant; typically, they keep a foot in the conventional world and assume socially valued identities by engaging in acceptable and productive activities while possibly concealing their deviance." (p.761)

An individual may have a family, a job, a home etc. (what Anderson and Levy may term "socially valued identities") but at the same time have a dependence on alcohol that they attempt to keep hidden from others. Participants' descriptions of experiencing shame and embarrassment, and feeling *"different to everyone else"* (Yasmin, ex-member, 18-months alcohol-free) because of their alcohol use, suggest they may have considered their secret drinking identity as 'deviant'.

Related to the concept of deviance is stigma. Research has found alcohol dependence to be a particularly stigmatised condition, more so than other mental disorders (Schomerus *et al.*, 2011a), and stigma is a key reason for patients to avoid seeking treatment (Keyes *et al.*, 2010; Probst *et*

al., 2015). Stigmatising labels and idioms such as *'once an addict, always an addict'* can become self-defeating thoughts, and prevent someone moving on in recovery (Biernacki, 1986; Kellogg, 1993), with association shown between self-stigma and lower drinking-refusal self-efficacy (Schomerus *et al.*, 2011b). Almost all participants spoke of both perceived social stigma and self-stigma attached to problematic drinking, reinforcing their desire to keep this aspect of identity hidden.

Like in Goffman's (1959) theatre, participants enacted a role to satisfy their audience. Participants appeared to use what Goffman terms 'impression management' - strategies to create a desirable image. By emphasising performances associated with a 'normal' life filled with responsibility, they could distract from their 'backstage' identity defined by problematic alcohol use. An actor's identity risks being blemished if an audience detects discrepancies between their social performance (the actor's 'virtual identity') and their 'actual identity'. Thus, for my participants, problematic alcohol use was considered a 'discreditable stigma' (Goffman, 1963) – an attribute that can to a certain extent be concealed, but if uncovered is likely to be frowned upon. Scott (2015) notes that 'invisible' stigmas like secret problematic drinking present a "double-edged sword" (p.157) because they allow the person to continue 'normal' social interaction without stigmatisation, but results in constant fear of being caught. This certainly reflects the experiences of participants who reported feeling *"isolated", "trapped"* and *"lost"* trying to juggle their multiple facets of self.

4.5.2 Lurking for reassurance

Due to this hidden identity, participants often relied on the Internet for information and advice about problematic drinking, and this was a common route to finding *Soberistas*. Upon finding the site, many reported time spent 'lurking', that is, passively *"consuming all the material"* without actively contributing. Many read stories of likeminded people with similar backgrounds and experiences and described a "resonance" with the site's ethos. 'Lurking' often provided reassurance:

> *"Reading other people's stories was so important because it made me realise I wasn't alone…to know that it wasn't unique to me, but there were people exactly like me…my age, my profession, my social background."* (Angela, member, 2-months alcohol-free).

'Lurking' therefore afforded participants a safe way *"to read and get information"* (Dave, member, 1-year alcohol-free) from supportive people with similar experiences yet preserve the secrecy that characterised this phase of recovery. Kimberley (member, 2-months alcohol-free) explained it was *"very reassuring to know that actually I wasn't going mad."*

Almost every participant spoke about the benefit of 'lurking' to access support anonymously, which was considered especially important during early recovery. Michelle (member, 5-months alcohol-free) explained:

> *"You want to keep a lid on it so much; you want to contain it yourself…it's a huge comfort that you're shrouded – there's no spotlight on your real life."*

Other research has also highlighted the role of the Internet in allowing users to lurk anonymously. Cooper (2004) developed a 'pathways disclosure model' (PDM) which described how problem gamblers used an online mutual aid group to support their recovery; as for my participants, anonymity and minimal personal disclosure was common at the start. Cooper (2004) suggests the Internet supports early exploration of behaviour change (i.e. those in pre-contemplation and contemplation stages of change[3]) because the person is not required to reveal any personal information or make any concrete commitments. This was a key benefit of *Soberistas* for many participants; Angela (member, 2-months alcohol-free) said the best thing about the site is *"the ability to engage with it when I need to, but there's no pressure to engage"*.

4.6   Addressing the 'alcohol identity'

While participants described arriving at *Soberistas* in various stages of change, all spoke of motivation to change their alcohol use or remain alcohol-free. Many described how alcohol had taken a central role in their lives, and several said they had a reputation for being the *"group drinker"* or *"life and soul of the party".* Participants described how their alcohol-related identities became destructive and had the potential to jeopardise other identities (e.g. as a parent, an employee, or an *"efficient coper"*). Most were fearful of this becoming a reality and reported

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[3] The transtheoretical model (TTM, Prochaska and DiClemente, 1983) of behaviour change considers an individual's readiness to address a given (usually unhealthy) behaviour. The TTM describes a series of temporal stages an individual progresses through when changing behaviour:

- **Precontemplation**; the person is not contemplating any behaviour change and may be unaware that their behaviour is problematic
- **Contemplation**; the person starts to realise their behaviour is problematic and begins to consider the costs and benefits of changing their behaviour
- **Preparation**; the person intends to make changes to their behaviour in the near future and starts putting plans in place to facilitate this
- **Action**; the person makes observable changes to their behaviour
- **Maintenance**; the person is sustaining action for a length of time and is working to prevent relapse

seeking support to stop drinking before this happened; Maria (ex-member, 2-years alcohol-free) said: *"I was having functional relationships, holding down a job, being a mother to my children…but it was just like a dark shadow over me."* The 'crystallised self' theory of identity (Tracy and Trethewey, 2005) holds that multiple facets of self are healthy and functional; however, my analysis highlighted the difficulties participants experienced when certain facets were felt to be unhealthy and dysfunctional.

This second concept captures participants' experience of addressing their destructive alcohol-related identities, including:

- how they realised there might be a problem (4.6.1: 'droplets of awareness')
- how they understood and interpreted the problem (4.6.2: 'becoming alcohol free')
- how *Soberistas* helped in this process (4.6.3: 'establishing accountability')

Prior research has found that recovery often involves a transformation of identity where the person leaves behind the old 'addict' identity, and establishes a new, more favourable identity which excludes addictive behaviours; this body of literature is discussed in relation to the findings presented below.

4.6.1 "Droplets of awareness"

Some studies have found evidence of participants experiencing a single 'crisis point' or 'rock bottom' moment as the reason for change, e.g. (Mackintosh and Knight, 2012; McIntosh and McKeganey, 2001; Teruya and Hser, 2010); however, participants in the present study tended to describe a gradual realisation that alcohol was causing problems; Linda (member, 15-months alcohol-free) referred to this process as *"droplets of awareness"*. For some, these droplets came in the form of many small incidents, for example:

> *"I don't think I've had…I mean I've had lots of moments…but I've always gone back to it, so I can't say…these people talk about how they have hit 'rock bottom' – I feel like I've done that loads of times – there's not one kind of pivotal moment where I thought, right I need to stop."* (Abby, member, currently drinking)

For others, these 'droplets' were recognition of a change in drinking pattern and style which gave cause for concern, for example:

> *"Two nights in one week I…I was going to say discovered…but yes it was, I had discovered I had drunk a whole bottle of wine, and I thought what on earth am I doing?"* (Sarah, member, 3-months alcohol-free)

> *"I guess where I started to get uncomfortable with things was probably mid to late thirties, when I was very conscious of the fact that I started to use alcohol to unwind at the end of the day, and then you know over time, the consumption crept up."* (Dave, member, 1-year alcohol-free)

These multiple incidents or general feelings of discomfort about one's drinking often resulted in 'exhaustion' with life as it was; Caroline (member, 3-years alcohol-free) referred to the AA saying, *"sick and tired of being sick and tired"*, to explain how she felt at the point of being ready to give up alcohol. Participants' descriptions of struggles to give up alcohol were laced with frustration because of the repetitive and relapsing nature of addiction; Heather (member, currently drinking) said, *"you hate yourself, you know, every day you think how you're not going to do it again"*. Sonia (member, 7-months alcohol-free) agreed:

> *"I'd wake up every morning and think right that's it…end of…I'm not doing it anymore. But then 4 o'clock, 5 o'clock would creep round by which time I was feeling better…down to Tesco's, get another bottle, and the cycle would start again – it was just getting so awful."*

Many participants were aware their drinking had an impact on other aspects of life, and this gave cause for concern. Some explained they regularly went to work with a hangover, others confessed they would sacrifice time with their children to drink, and many discussed the negative impact it had on their psychological health and mood. Linda (member, 15-months alcohol-free) explained how alcohol took over her thinking, she said; *"alcohol took a space in my brain that was just for alcohol. It's described as 'the voice'"*. Many expressed regret and sometimes shock at how alcohol had infiltrated so many aspects of self, although participants were generally still able to project a socially accepted version of themselves to others (Goffman, 1959). This finding resonates with the experience of marginality in which the person struggles with a divided sense of self and confusion over identity, resulting in instability and stress (Stonequist, 1937); Dave (member, 1-year alcohol-free) summed this confusion up well:

> *"The frustrating thing is when you realise the equation doesn't quite add up any more and it's [alcohol] taking more from you than it's actually giving, but you still can't quite break the connection. It's like having a love-hate relationship…it's like having an abusive partner…you can't quite bear to let it go but you know it's not good for you – you keep going back for more."*

Intolerance of the state described by Dave often drove participants to stop drinking. An important early study looking at the process of recovery from addiction was conducted by Biernacki (1986) whose findings resonate 30 years later with experiences of participants in the present study.

Biernacki found that the decision to stop using a substance was often a consequence of an individual's 'addict identity' conflicting with other non-addict identities (e.g. as an employee, a parent etc.). The impact of a "spoiled identity" requires the person to re-evaluate and repair their damaged sense of self. McIntosh and McKeganey (2000;2001), in their interviews with 70 recovering drug users in Scotland, also found that recognition of identity being 'spoiled' through defamatory characteristics and behaviours associated with drug use, was an important step in recovery.

In Gibson and colleagues' (2004) grounded theory study of drug users' concerns and experiences of their oral health, a core concern identified was the 'entangled' nature of their identity (i.e. unstable, chaotic), and the effort they had gone to, to 'disentangle' during the recovery process. Many reported feeling guilt and self-loathing for once being a person entangled in drug use. This echoes participants' experiences in the present study, for example:

> *"There is that sort of, 'oh god why did I do that?' – even if you haven't gotten very drunk. You know, I meant not to drink ever again, and I've had three glasses of red wine. And that doesn't make you an out and out 'alcoholic', but it makes you somebody who can't stick with what they said they were going to do, and you feel just as bad."* (Rachel, member, 2-weeks alcohol-free)

The lack of evidence for a defining 'turning point' in my interviews with participants supports the findings of Granfield and Cloud (1999) that *numerous* and intertwining factors may prompt the initiation of recovery; this gradual "drift" out of addiction mirrors the drift into addiction where participants were generally unaware of their mounting reliance on alcohol as it gradually increased over time. The 'droplets of awareness' notion also supports elements of Kearney and O'Sullivan's (2003) identity shift theory, described in Chapter 1; accumulating evidence that alcohol consumption was incongruent with other identities and values prompted critical self-appraisal (Kearney and O'Sullivan's "taking a hard look at myself" category, p.144), leading to subsequent behaviour change.

4.6.2   Becoming "alcohol free"

An obstacle to accessing traditional treatment, or other forms of mutual aid including AA, was participants' general reluctance to accept an 'alcoholic' identity. The term was considered by those who mentioned it to be derogatory, stigmatising and something with which they could not identify: *"I fundamentally did not, and still do not believe that I was 'an alcoholic'"* (Hayley, ex-member, 3-years alcohol-free). Furthermore, many did not consider their drinking to be a *"medical problem"*, often agreeing with Kimberley (member, 2-months alcohol-free) who said, *"I*

don't subscribe to the disease model…you don't have a disease, you have a problem with drinking". Many reported no physical health consequences of their drinking and stated the main symptom of problematic consumption was reduced mental health.

Robinson's (2016) recent commentary encourages clinicians to avoid using non-diagnostic idiosyncratic terms like 'alcoholic' or 'addict', as they perpetuate negative beliefs and attitudes; he argues that a person-first, patient-centred approach to clinical labelling is crucial if the treatment utilisation gap is to be reduced. This publication aligns with a memo (see Box 1 below) I wrote during early stages of interviewing when it became apparent that language and labelling was important for understanding participants' experience of recovery.

Box 1: Memo on the importance of language and labelling

Second interview with Kimberley has raised some interesting questions: she totally rejects the "disease model" approach to understanding her drinking. She did not identify with the word "alcoholic". Is this just her individual perspective, or is this true for Soberistas as a whole? Maybe Soberistas appeals because of the framework it provides members to understand their drinking, which excludes the need for stigmatising labels (like 'alcoholic')? Kimberley said she would never go to AA or her GP because of the label she would be given. What label (if any) is used on Soberistas? This interview has brought to my attention the role of language and terminology in recovery.

Participants felt *Soberistas* offered an alternative perspective to other treatment models, although the site was said to have a clear ethos, characterised by specific language, values, norms, and beliefs. Kevin (member, 2-years alcohol-free) explained:

> *"The first night I was on…the first message I got was, "how long are you AF?" Well I didn't know what 'AF' was – I was actually too embarrassed to ask what 'AF' was. I kind of worked it out myself…I thought that must be 'alcohol-free'."*

Numerous participants spontaneously used the term 'alcohol-free' during interview which they explained was central to the *Soberistas* 'identity', being *"softer than saying ex-alcoholic"* (Louise, browser, 3-weeks alcohol-free). Participants welcomed the *"softly, softly approach"* (Angela, member, 2-months alcohol-free) advocated on *Soberistas;* viewing the decision to give up alcohol as a "healthy lifestyle" choice helped many accept their problematic alcohol use without evoking shame. Abby (member, currently drinking) explained:

"What I like [about Soberistas] is that it's not shaming…it just helped me to not feel really crap about myself because I could see that other people had this problem…other women with children and jobs…not necessarily down and outs."

Other qualitative research with people in recovery from alcohol dependence has noted the negativity attached to an 'alcoholic identity'. Khadjesari et al.'s (2015) study looking at experiences of using 'Down Your Drink', an online intervention offering help and advice on reducing alcohol consumption, found that users of the site likened 'alcoholics' to "smelly tramps in the street" (p.2016). Similarly, Hill and Leeming's (2014) Interpretative Phenomenological Analysis with six individuals engaged with AA identified a key theme, "men in dirty macs"; this summarises participants' prior expectation of who attends AA meetings, and reflects how they thought society views people with alcohol problems. Biernacki (1986) also recognised social stigma as an obstacle that needs to be overcome if people are to successfully recover; rejection of the 'alcoholic' identity appeared to be a mechanism for participants in the present study to detach themselves from such stigma.

The way in which participants appeared to make sense of their alcohol use, in relation to their overall sense of self, led me to the work of Brekhus (2003), despite the disparity in topic area (Brekhus' analysis focuses on homosexuality). His "identity grammar" framework suggests that people can use identity labels as essentialising nouns (i.e. the label captures the person's fundamental essence; "alcoholic" is *who* the person is) or descriptive adjectives (i.e. the label is a description of a person's behaviour; "alcoholic" refers to a pattern of drinking). Participants in my study appeared to conceptualise their drinking in terms of a destructive *behaviour* that has the potential to impinge on valued identities, rather than problematic alcohol use representing their fundamental essence as a person.

Despite rejection of the 'alcoholic' label, participants explained that *Soberistas* shared one important element with AA – namely its belief about complete abstinence as the only solution for people with alcohol problems. Members of *Soberistas* were expected to endorse this alcohol-free identity when online – Sarah (member, 3-months alcohol-free) explained that to fully integrate into the community she had to *"earn [her] stripes"* and equated this with being alcohol-free; she said, *"I've been sober 88 days…I can justify being part of the group now"*. Another participant explained the only requirement for joining was a *"commitment and desire to be alcohol-free"* and the concern if someone expressed contradictory opinions:

"There would be quite a big backlash and it's usually the newer people – the 'newbies' – that really don't understand what all the fuss is about. But it's about maintaining the ethos of the site and what it stands for." (Karen, member, 13-months alcohol-free)

This 'alcohol-free' ethos encouraged some participants to think differently about their drinking. Kerry (member, 3-months alcohol-free) explained that *Soberistas* made her realise she was *"attacking it wrong"* – she said:

> *"On Soberistas this woman had what I considered to be a lesser problem than mine, and she was giving it three times as much commitment as I was, so I realised I needed to give it 110%, and I tripled mentally what I thought my problem was, and therefore I won't touch a drop."*

While firm 'rules' around abstinence gave some participants the impetus to take their drinking seriously, others described feeling "intimidated" by members who advocated an abstinence-only approach, Liz (member, currently drinking) explained:

> *"I said I was thinking of having a drink – I got lots of support, but I also got lots of aggressive comments. Then when I did drink, I blogged about it, but it got really quite nasty…I stopped blogging."*

Liz later stated she would not renew her membership because of "hostility" from others, and the site's inability to support her attempt to moderate drinking. Other participants explained that to stay part of the community, they had to refrain from vocalising opinions that do not support the abstinence-only ethos. Heather (member, currently drinking) said:

> *"I would like to sit in a nice bar and have a glass of red wine, which I have done – but I don't say that on Soberistas. The general atmosphere of it is don't drink. I don't think it says it in any of the rules or anything, but it's just the accepted wisdom. If you want to talk about drinking in moderation, please keep away from all these people who are trying to not drink at all because it's hard enough."*

Therefore, at times, participants were required to foster an online identity that differed from their offline identity(ies) to protect the site's alcohol-free ethos. *Soberistas* might not benefit these members in the same way as those seeking complete abstinence, and some research has supported moderation as a viable treatment goal, particularly for non-dependent problem drinkers (Humphreys and Klaw, 2001; Klaw and Humphreys, 2000). However, for those whose goal is abstinence, engagement with a group that cultivates strong values around abstinence may nurture the development of a personal identity defined by motivation to not drink. West's (2006) PRIME theory argues that to remain abstinent from addictive behaviours, the individual's motivation not to smoke/drink/gamble etc. must be linked to their 'deep-identity' – the "self-ascribed labels and attributes to which the individual is emotionally attached" (West, 2009, p.280). Thus, the labels people ascribe to themselves can have a profound influence on their

behaviour. West (West, 2006) suggests that 'ex-' or 'non-' smokers experience more motivation not to smoke because of the label they have assigned to themselves, and research has found that having a positive 'smoker' identity independently predicts failure to make a successful quit attempt six months later (Tombor *et al.*, 2013). Thus, the ability to develop a strong identity that excludes the addictive behavior may determine whether an individual successfully recovers or not (Best *et al.*, 2016; Frings and Albery, 2015). A recent study conducted by Montes and colleagues (2017) found that in non-treatment seeking hazardous drinkers, those who transitioned from identification as a 'problem drinker' to identification as a 'non-problem drinker' were seven times more likely to rapidly reduce heavy drinking than those who did not make such a change; these participants also had significantly less heavy drinking days at the 2-year follow-up point. The authors argue that change in subjective appraisal of one's identity in relation to alcohol use is an important indicator of change in drinking behaviour. Here, the ethos promoted on *Soberistas* appeared to be facilitating change in its members by encouraging the development of an identity that is truly "alcohol-free".

4.6.3 Establishing accountability

While many participants reported lurking on *Soberistas,* especially at the beginning of their membership (see Section 4.5.2), some emphasised the importance of 'creating an identity' on the site by actively participating. Linda (member, 15-months alcohol-free) recalled the transition between lurking and participating;

> *"I started tapping into the site and reading every so often, and then I thought, I've got to do something about this...I must have read on the site for a few months before I ever did the first blog."*

Another participant, Michelle (member, 5-months alcohol-free), wrote her first blog the day she stopped drinking. She explained;

> *"Once you create an 'identity', and you put yourself out there on blogs or commenting on other people's blogs, you're almost a little bit, in your heart of hearts, accountable…there's almost, well I'm out there now…you're accountable to everybody."*

Alcohol-free members frequently discussed the importance of accountability in sustaining abstinence, and a mechanism for accountability is active engagement on the site. This was corroborated by participants who reported non-engagement and lack of accountability when drinking, for example:

"When I was going through a moderating phase, I didn't really look at the site…I didn't really want to engage. Using the site is for me to not drink…when I am drinking I kind of don't see the point." (Kimberley, member, 2-months alcohol-free).

Establishing smaller, more personal communities within the larger *Soberistas* network was a common way of creating accountability. Participants explained that members often joined others with similar demographics (e.g. age), goals (e.g. 30-days alcohol-free) or interests (e.g. yoga), and this helped foster "mutual support" and "understanding", which often paved the way for "intimate" and "real" friendships on *Soberistas,* occasionally involving in-person meetings.

Engagement with likeminded people also provided alcohol-free participants with reaffirmation of their decision to remain so, despite possible resistance or lack of understanding from people offline:

"It's a bit hard because they [friends/family] don't understand, but that's why I get solace in the website and from reading Lucy's [Soberistas' founder] book…because those are people, even though I've never met them, they can understand…no-one else understands why I've given up." (Maria, ex-member, 2-years alcohol-free)

Some participants cited lack of understanding and perceived stigma in their offline lives for confining expression of their difficulties with alcohol on *Soberistas.* Many wished to keep online and offline identities separate, and when this was jeopardised, some reported feeling fearful. For example, Kerry (member, 3-months alcohol-free) explained what happened when a friend joined *Soberistas*:

"I went for a dinner party locally and a friend mentioned it [Soberistas]…I just ran home that night and deleted everything because I've got far too much personal information on there…it terrified me…I haven't blogged since."

This fear of being recognised caused some participants to keep their offline identity hidden on *Soberistas,* and many discussed the benefits of doing so, namely the ability to *"open up about things they wouldn't normally"* (Tina, member, 1-month alcohol-free) – anonymity therefore encouraged personal disclosures, and was often considered helpful for recovery:

"I just found it easier to talk about the whole subject anonymously…it becomes terribly easy to talk about it in a third person almost, as if you're somebody else, and I found that very helpful. I found it much easier to admit that I was sitting there at 9 o'clock in the morning with a bottle of vodka." (Ben, member, 3-years alcohol-free)

The freedom to selectively 'self-present' (Goffman, 1959) online permits the construction of an identity/identities that exist alongside others in the 'real world'. The use of the Internet is therefore interesting for identity construction because as McEwan and Mease (2013) note, the relationship between physical self (e.g. age, gender, race), location (e.g. home, work) and audience – all of which provide information about membership to identity groups and determine which identity is enacted – is "altered" (p.87-88). Participants appeared to use *Soberistas* as a vehicle to effect change in their drinking but could exercise control over the level of personal disclosure; individuals could balance their need for connection and understanding with their desire for anonymity. This flexibility was considered a benefit over in-person treatment which requires exposure of identity. For many, the *Soberistas* community provided a *"rare opportunity to offload"*, in an anonymous environment, to supportive people who understand – Angela (member, 2-months alcohol-free) explained that was *"the kick-start behind making changes"*. Goffman (1959) discusses 'dramaturgical loyalty' which refers to team-mates being bound by moral obligation to keep off-stage secrets and backstage identities hidden from certain audiences; it seems loyal users of *Soberistas* had entered into a such an agreement about their experience of and recovery from problematic alcohol use.

A body of literature concerning social identity was particularly relevant for the theoretical integration of this concept and associated categories. Until now, the studies presented highlight the importance of 'personal' identity projects, which focus on transforming a 'spoiled identity' into an 'unspoiled' or 'non-addict' identity. However, Neale et al. (2011) argue that the 'spoiled identity' concept is over-simplistic, and emphasises the identity associated with substance misuse at the expense of neglecting other important identities the person might hold. Indeed, while many participants in the current study did discuss their destructive drinking identity, they also emphasised various other identities such as parent, employee, wife etc. (see Section 4.5).

In her work with ex/users of heroin, Hughes (2007) also concludes that we should move away from understanding addiction just at the level of 'the individual' because recovery also necessitates changes in lifestyle, social involvement, and engagement. Thus, identity transformation "is not only dependent on what users will and can do, but what they will and can do in the context of the willingness of others to engage in, and support, such change." (p.688). Even Biernacki (1986), in discussion of how to overcome a 'spoiled identity' (i.e. a personal identity), suggests an individual is more likely to recover if they have access to a range of 'identity resources' – including 'healthy' non-using social relationships, social roles, and vocabularies – from which a new identity (or identities) can be established.

The importance of recovery-specific support from abstinent peers for successful short and long-term outcomes is well stated within the literature, with benefits including: changes in levels of substance use (Kelly, 2017; Kelly *et al.*, 2012a; Litt *et al.*, 2009; Longabaugh *et al.*, 2010; Stout *et al.*, 2012), retention in treatment (Beckwith *et al.*, 2015; Bliuc *et al.*, 2017) and improved quality of life and mental health (Bathish *et al.*, 2017; Best *et al.*, 2012; Best *et al.*, 2015). Other research has found that exposure to the norms, values and beliefs of a recovery network encourages the development and maintenance of a 'non-addict' identity, e.g. (McIntosh and McKeganey, 2000; Pennay, MacLean and Rankin, 2016; Rodriguez and Smith, 2014). In the context of a 12-step group, Buckingham and colleagues (2013) found that members who established a strong preference for a social identity aligned with recovery rather than that of 'an addict' had higher levels of self-efficacy, which itself was positively correlated with months abstinent. These results concur with accounts of participants in the present study; those who appeared to benefit most from *Soberistas* membership had established small accountability networks and embraced the alcohol-free group identity. Larkin and Griffiths (2002), in their IPA study of a 12-step residential treatment centre in England reported similar results – those who could more easily relinquish their 'addict' identity in favour of the new dominant group identity were more likely to be positive about the future and receptive of support; the creation of a new 'sober/recovering' identity creates distance between the former, unfavourable identity and boosts self-efficacy in the quest to stay sober.

Thus, although the title of this results section concerns the *individual's* 'alcohol identity', the data within this concept also supports a role for social identity in the recovery process; the creation of smaller friendship groups on *Soberistas,* for example, provided some participants a framework to support the development of their new (personal) alcohol-free identity. Best et al.'s (2016) social identity model of recovery (SIMOR), described in more detail in the introductory chapter of this thesis, is relevant here. SIMOR frames recovery as involving the person's social world and suggests that changes to this world occur alongside changes in a socially derived sense of self (Best et al., 2016). A 'social identity' perspective recognises that people do not live in isolation, uninfluenced by their social networks and group membership, see also: (Frings and Albery, 2015; Rosenquist *et al.*, 2010). Engagement with *Soberistas* represented a change in the social world of participants which provided a sense of belonging and unity with others *"who understand"*.

4.7   Creating an "authentic self"

This final concept captures the experience of some participants who managed to move on from occupying multiple identities, including a secret drinking identity, to creating what they termed an *"authentic self"*. Philosophical and psychological theories of self and identity have long discussed

the notion of a 'true' or authentic self, which some research has suggested is crucial for psychological health and well-being (Schlegel *et al.*, 2009). Some participants explained they arrived at a stage where they allowed their on- and -offline identities to be viewed simultaneously, and this helped toward a feeling of authenticity (and was considered a positive step forward in recovery). The convergence of identities was almost always described by participants who had achieved some period of sobriety and had progressed further in terms of stage of change; their experiences were compared with those of participants earlier on in the process, which consolidated the theory presented here.

4.7.1 Being "secure in sobriety"

Several participants described what Caroline (member, 3-years alcohol-free) termed as being *"secure in sobriety".* This state marked a significant change, going beyond simple acceptance of needing to be alcohol-free:

> *"This is a new chapter in my life and it's very different. I am absolutely delighted with it…I'm really happy."* (Hayley, ex-member, 3-years alcohol-free)

Yasmin (ex-member, 18-months alcohol-free) indicated this happiness came from arriving at her *"authentic self".* Participants explained part of this authenticity involved a change of lifestyle and engagement with new activities (e.g. study, exercise, volunteering), and spending time with new non-drinking friends. It also meant a *"sense of freedom"* because they reached a point of openness both online and offline:

> *"I don't care what people know about me, you know at the meet ups we use our real name and photographs were taken…couldn't care less now if some of my personal friends think that I was an 'alcoholic'…that's the label they might want to use."* (Karen, member, 13-months alcohol-free).

The interview with Karen prompted a memo (Box 2), related to the one presented earlier (Box 1), about terminology and language in recovery, and demonstrates progression of the theoretical framework:

> Box 2: Memo on the importance of language and labelling
>
> *Interview 5 – like the other participants I have interviewed, Karen rejects the "alcoholic" identity, but unlike the others, Karen <u>doesn't care</u> if that is what she is labelled as. She has been AF for longer than most of my other participants – is it related to that? Caroline (interview 1) was 3 years AF at time of interview and she provided the in vivo code, "secure in sobriety". Maybe Karen and Caroline have progressed to a different stage in their recovery, and a different stage in their identity? Is labelling less of an issue for participants with longer periods of sobriety?*

It was only through subsequent interviews that the concept of *creating an "authentic self"* (in vivo code from interview 28 with Yasmin) by being "secure in sobriety", came to fruition.

Authenticity also meant for some participants a sense of freedom in their thinking, for example, Linda (member, 15-months alcohol-free) said:

> *"There was a part of my life that was taken up with thinking about it, you know, when you would have a drink…how much you could have a drink…how much you could drink and not to be seen to be drinking too much – and all of that I have lost completely. That has gone. I feel…it's a sense of freedom. I think I was trapped by alcohol, and I feel completely free now."*

Other participants in earlier stages of recovery described looking forward to a time where alcohol would no longer play a central role in their lives. Sarah (member, 3-months alcohol-free) said she *"is hoping in time this will all go away…put it behind me"*.

Previous research supports the finding that successful recovery requires breaking away from old networks and activities and establishing a new sense of self; McIntosh and McKeganey (2001) argued that their participants' narratives of recovery, which included distancing themselves from drug-using activities and social networks, and reconstructing their sense of self, provided evidence for the creation of a new identity. More recent work by Dingle and colleagues (2015) also attests to this; through semi-structured interviews with 21 adults residing in a drug and alcohol therapeutic community, the authors identified two 'identity pathways' into and out of addiction. One was termed "an identity gain pathway" in which socially isolated individuals saw the initiation of their addiction as the development of a new valued social identity, or their recovery in terms of building new identities involving work, study, or family roles. While there is no evidence of participants in the current study gaining a valued social identity through their addiction, there is

evidence of their recovery involving the construction of newly gained identities. Karen (member, 13-months alcohol-free), for example, said her identity has changed *"dramatically"*:

> *"I have become a bit of a fitness, health...I was always quite fit and healthy, apart from the drinking, but I'm like uber fit now [laughs]."*

Thus, participants appeared to replace their destructive drinking identity with positive facets of self by establishing new personal narratives defined by health. Pennay et al.'s (2016) research into the online programme, 'Hello Sunday Morning', also identified narratives of "healthism". The authors found that many participants who stopped drinking became focused on fitness, mental wellbeing, and success in other areas of life; they note that "alcohol, then, becomes an 'unhealthy' practice, one that is framed as inauthentic and unnatural" (p.73). In both Pennay et al.'s study and mine, engagement in recovery-orientated activities and support from like-minded others (both on- and off-line) appeared fundamental to this increased sense of authenticity. This is in keeping with Reith and Dobbie's (2012) longitudinal work with problem gamblers; the authors found that *personal* identity reconstruction was grounded in *social* circumstances and relationships. Similarly, Koski-Jannes (2002) noted that recovery efforts require long-term changes in both personal *and* social identity in their mixed-methods study based in Finland of 76 participants in recovery from various addictions. Personal identity projects involved, for example, finding a more authentic expression of being, getting back in touch with emotions or searching for a spiritual solution; social identity projects included being part of a mutual aid movement, helping others with similar problems (see next section on 'leading') or simply fitting into mainstream society as "ordinary tax payers" (p.192). The desire to preserve connection to the "mainstream" (Nettleton, Neale and Pickering, 2013) was apparent in the interviews I conducted and supports Waldorf et al.'s (1992) finding that maintaining a stake in 'conventional life', with its "ingredients of a 'normal' identity" (p.10), was important for cocaine users to control their use or quit completely.

Relevant to these findings is Howard's (2006) research which examined the role of disorder labels (e.g. 'alcoholic', 'anorexic', 'acrophobic') in recovery. Analysis of recovery narratives of individuals who had 'dis-identified' with their disorder labels highlighted that labels can narrow self-perception and stunt personal growth because of the perceived permanency attached. Howard provides the narrative of one participant, Vicky, who explained that she did not want to be an 'alcoholic' forever; she did not want to "be a survivor of anything" (p.318). This resonates with participants in my study who wanted to distance themselves from their historical problematic alcohol use and move on with their healthy, alcohol-free lives. By refusing their problematic alcohol use to be rigidly defined as an essentialising noun (Brekhus, 2003; Pienaar *et al.*, 2016),

participants could "see themselves in less definitive, more fluid ways" (Granfield and Cloud, 1999, p.111).

4.7.2   Leading

Some participants moved from 'participating' on *Soberistas* to 'leading', and this was considered a helpful mechanism for creating an "authentic self". Participants either self-identified as leaders, or referred to others in 'leadership' roles – for example, in discussing a small thread she was part of, Sarah (member, 3-months alcohol-free) described the group founder as their *"mother hen"*, and Linda (member, 15-months alcohol-free), the leader of another group said, *"When I started the discussion…I had progressed to being a grown-up [laughs]"*.

Participants explained that members earned 'leadership' status through consistent online activity over time and continued abstinence, congruent with the *Soberistas* ethos. Attribution of leadership status was informal; essentially some members were *"role models"* (Sonia, member, 7-months alcohol-free), acting like *"sponsors [as in AA] without the title"* (Paul, member, currently drinking).

Those who considered themselves leaders described a sense of obligation *"to give back to other people who are just starting out"* (Michelle, member, 5-months alcohol-free), from which they too benefitted:

> *"It's kept me more on the straight and narrow because I'm running this blooming discussion forum…no weakness allowed!"* (Linda, member, 15-months alcohol-free).

In a recent study guided by the theoretical tenets of SIMOR, Best and colleagues (2018) found that in an online recovery community created on Facebook, "old members" who had a long-standing commitment to the group, played a key role in facilitating social cohesion among members. They acted as "bridges" between other members and the wider community, offline. Leaders on *Soberistas* demonstrated "bridging" through their reduced anonymity both on- and offline. Jenny (member, 5-years alcohol-free), a self-professed leader said, *"I thought I'm going to be open…known by my own name…and I was going to stand up and be counted for"*. Jenny explained she hoped by revealing her personal identity on *Soberistas*, others would follow. She considered it important to give a face *"to this hidden group"* and reduce stigma attached to problematic drinking. Some participants described becoming *"evangelical"* about their sobriety offline by shouting about the benefits of not drinking and recruit people to the *"sober revolution"*, with Ian (browser, 5-years alcohol-free) going as far as to say he considers it a *"personal jihad"*. Others also expressed passion in discussing *Soberistas* – Linda (member, 15-months alcohol-free)

said, *"I'm a Soberista and proud of it!"* Moreover, instead of being burdened with a label perceived as negative and/or stigmatising (e.g. 'ex-alcoholic'), participants could be congratulated on their decision to lead a healthy lifestyle as a *'Soberista'*:

> *"Everybody thinks I'm so wonderful [laughs]...it's daft really, they say 'ohh you're so wonderful' [laughs]."* (Linda, member, 15-months alcohol-free)

The positive feedback received from recovery-supportive relationships and activities (like 'leading' on *Soberistas*) may increase confidence and motivation to continue the change process, as it is validated by others (cf. Barker *et al.*, 2018). Johansen et al.'s (2013) grounded theory study of addicts and their sponsors, recruited from an addiction recovery social support programme in Norway, also found benefits for the individual to feel useful and be able to help others – this 'role reversal' led to increased self-esteem and contributed to a positive life-sustainable identity. This resonates clearly with experiences of the 'leaders' I spoke with on *Soberistas*; they explained that helping others, helped them.

4.7.3 Moving on

Participants described 'moving on' from *Soberistas* at different stages in their recovery journey. Many who reached a stage of security and authenticity moved on because they no longer relied on it to maintain sobriety or felt the need to give back any more - *"It fulfilled its function...I am in control of my addiction and I feel perfectly able to deal with it"* (Ben, member, 3-years alcohol-free). Dave (member, 1-year alcohol-free) agreed:

> *"I feel like in my journey I have taken everything out of Soberistas as I can and put as much back in as I could – but I'm in a different stage of my journey now and I don't really need it."*

Others moved on because their peer group had dissolved, Paul (member, currently drinking) explained:

> *"There were just a few small groups of people I seemed to connect with, and the sad thing is they disappeared – it's a bit wearing having to explain yourself to new contacts all the time, so this year I have shied away from the chat side of things."*

Similarly, Karen (member, 13-months alcohol-free) said the only reason she would leave *Soberistas* is *"not being able to relate to people".* Several longer-term alcohol-free participants described feeling like "outsiders" because of the increasing number of new members who were only recently abstinent:

> *"I'm one of the old timers…with two years under my belt, I'm now looking, well there are people who are seven days and eight days…that's not me anymore."* (Kevin, member, 2-years alcohol-free).

Longer-term alcohol-free members perceived their needs to be different from newly-abstinent members and often withdrew from *Soberistas* when it no longer resonated. Some even described feeling irritated by other members who seemed unable to maintain abstinence, for example, Yasmin (ex-member, 18-months alcohol-free) said:

> *"I started to get irritated with some of the posts…you would see the same people posting again, and again, like they had managed 2 days without alcohol, and then fall…like "oh well I've made 2 days now, that's it, back to the wine" …and definitely that's when I started to give it a wide berth. I paid for like a year's membership at the start, and then decided not to renew because of that."*

However, because many considered the site to be an important part of their recovery journey, they often felt a deep "attachment" to it and continued to pay the subscription fee to support it financially and/or *"keep the security blanket"* (Kerry, member, 3-months alcohol-free).

4.8   Summary

This study explored the role of an online mutual aid group in helping individuals address their problematic alcohol use. My analysis, grounded in participants' accounts, led to the development of the theoretical framework, which highlights that through the management of multiple facets of self, and engagement with *Soberistas* in various stages, participants could embark on a path to recovery. The most linear and commonly discussed pathway of online engagement involved transitions from 'lurking' to 'actively participating' to 'leading', before 'moving on'; this journey coincided with participants' transition from problematic alcohol use to being *"secure in sobriety"* and accords with research into use of other online support groups (e.g. Cooper's (2004) study of problem gamblers).

A key finding concerns participants' conceptualisation of their problematic alcohol use in relation to self. As alcohol had little observable impact on daily life for most participants, with the majority not engaged in any formal treatment, they had the freedom to choose how they interpreted their drinking and incorporate it into their self-concept. This was an important consideration when participants were deciding where to go for support; online networks afford users control over how they present themselves (Merolli, Gray and Martin-Sanchez, 2013), and this flexibility appealed to participants. Individuals could balance their need for connection and understanding,

with their desire for anonymity. 'Lurking' afforded participants the opportunity to gain information and reassurance from similar people who had quit drinking, but also maintain secrecy about their use of alcohol and/or ambivalence toward change.

Participants were keen to maintain "normal" selves, defined by their socially valued identities within family, work, and wider society (Anderson and Levy, 2003; Nettleton, Neale and Pickering, 2013). Their outward impression of being responsible, "efficient", and "copers", meant friends, family and colleagues were largely unaware of their hidden struggles with alcohol. Even when participants tried to share concerns about their drinking, they were often dismissed because of their visible high levels of functioning in daily life. Most, however, preferred to maintain complete secrecy about this aspect of self to avoid jeopardising other valued identities, supporting the conceptualisation of identity as multidimensional and 'crystallised' (Tracy and Trethewey, 2005); participants appeared to engage in various social 'performances' to distract from their hidden or 'backstage' identity (Goffman, 1959). The fear of alcohol 'spoiling' these "normal" identities increased over time, eventually demanding critical self-appraisal which was often the catalyst for change and is in keeping with Kearney and O'Sullivan's (2003) identity shift theory – this contrasts with the "turning point" or "rock bottom" narrative often described in the literature (Kirouac, Frohe and Witkiewitz, 2015). Significant 'social capital' in the form of economic stability, positive relationships, and ideology defined by resilience, responsibility, and obligation, can serve as important resources helping people to overcome problematic substance use (Granfield and Cloud, 2001). Study participants reported being relatively well resourced in terms of social capital, and this may have equipped them to take control of their problematic drinking before it led to a pivotal rock bottom moment. The 'pulls' of the good life, rather than the 'pushes' associated with hitting rock bottom, seemed to be the motivator for participants to stop drinking (Waldorf, 1983).

A repeated theme in interviews was the perceived stigma attached to having an unhealthy relationship with alcohol. To manage this stigma, participants disassociated themselves with labels they deemed to be derogatory (e.g. "alcoholic"), and at least at the early stages of recovery, interpreted their drinking as an unhealthy behaviour that needed addressing, before it had negative ramifications for other, healthy aspects of self. That is, prior to the development of an 'authentic self', participants tended to view their drinking as a descriptive adjective, rather than an essentialising noun which governed their essence as a person (Brekhus, 2003). This finding resonates with Thoits' (2016) notion of 'identity deflection' which describes a conscious process of rebuffing the idea that one has a mental disorder to protect oneself from anticipated stigma. Thoits notes: "belief that one is not mentally ill makes the existence of cultural stereotypes inapplicable and thus minimally threatening to the self" (p.135-6). Her study of identity deflection in >1300 individual who met DSM-4 criteria for one or more mental disorders (including

alcohol/substance use disorder) found that those who more often deflected a mental illness identity had high levels of functioning, no treatment experience, held negative views about professional treatment, and occupied multiple social roles; this profile coincides greatly with the participants in my study. Her study also highlighted the positive benefits of identity deflection in terms of lower distress and more positive affect.

Soberistas appeared to work for those who endorsed an alcohol-free ethos but rejected 'disorder labels' associated with problematic drinking. While the abstinence-only approach aligns with AA principles, the mechanisms underlying this sustained behaviour change reflect a different process: AA members decide not to drink because they accept they are out of control and powerless in the face of alcohol (Cain (1991) described this acceptance as a transition from "drinking non-alcoholics" to "non-drinking alcoholics", p.210); *Soberistas* members decide not to drink because they want to take control and gain power over alcohol. If this philosophy resonated, participants often continued their engagement with the site by actively participating and creating systems of accountability with other members (e.g. forming small groups to 'check-in' on each other and monitor progress). This may have contributed to internalisation of the group identity, which supported recovery by facilitating the development of a stable non-drinking social identity (Best *et al.*, 2016; Frings and Albery, 2015), from which a personal 'deep identity', defined by abstinence, could emerge (Vangeli and West, 2012; West, 2006). McIntosh and McKeganey (2000) concluded that new abstinence-based identities are products of "the socially constructed nature of the recovery process" (p.1508), and it is clear from participant interviews that the *Soberistas* social community provided information from which participants derived their new recovery identity.

'Authenticity' marked a poignant change in identity construction. Participants who described arriving at this stage of change allowed their on- and off-line identities to be viewed simultaneously; this was most common for leaders and those firmly alcohol-free. For these participants, their online non-drinking identity blurred into their offline identities, and changes in 'real-life' social networks and activities were described. Many spoke of feeling liberated when abstinence defined both their on- and off-line identities, despite possible resistance from friends, family and/or colleagues. There was no longer the risk of 'getting caught' by audiences who might notice discrepancies between social performances and backstage identities (Goffman, 1959). Internalisation of the *Soberistas* group norms, supported by accountability and mutual support, appeared to become a personal resource in times of adversity (Jetten *et al.*, 2014).

The convergence of on- and off-line identities, although problematic in some situations, e.g. if one's self-presentation online might compromise one's offline professional persona (McEwan and

Mease, 2013), was considered a positive step forward in recovery for these participants. Returning to Brekhus' (2003) 'identity grammar' framework, it might be reasoned that participants with an authentic identity conceptualised their alcohol-free status in terms of an essentialising noun that provided a positive basis for living. While disorder labels, such as 'alcoholic', might be rejected because of the negative permanency attached (Howard, 2006), 'recovery labels', such as being a '*Soberista*', might play an important role in helping some individuals maintain their goal of abstinence by encouraging the development of positive self-schemas (Corte, 2007) to which the person is emotionally attached (West, 2006). Also, being a *'Soberista'* provides new members and browsers orientation to a future 'possible self' and gives "direction for their healing" (Howard, 2006, p.314). This finding differentiates *Soberistas* from traditional 12-step mutual aid philosophy where members tend to retain an 'alcoholic' or 'addict' identity, even when they are in recovery.

4.8.1 Strengths, limitations, and original contribution

The existing literature on identity processes in recovery is limited by a focus on addiction to substances other than alcohol, e.g. (Biernacki, 1986; Gibson, Acquah and Robinson, 2004; McIntosh and McKeganey, 2000;2001; Tombor *et al.*, 2013), or to studies conducted within an AA context, e.g. (Cain, 1991; Hill and Leeming, 2014; Weegmann and Piwowoz-Hjort, 2009). My research therefore contributes to filling this important gap. Furthermore, evidence of the multidimensional nature of identity was perhaps more readily tapped into because this research involved an online group, where the relationship between physical self, location, and audience is altered (McEwan and Mease, 2013). While there is some evidence of the effectiveness of online *interventions* for alcohol use (Sundström, Blankers and Khadjesari, 2017), there is less research exploring recovery through engagement with online groups underpinned by mutual aid and social support, e.g. (Coulson, 2014; Cunningham, van Mierlo and Fournier, 2008; Humphreys and Klaw, 2001; Pennay, MacLean and Rankin, 2016). The Internet lends itself as an interesting platform for identity research in the addictions and I hope these findings will encourage further research in this area.

A key strength of this study was the use of constructivist grounded theory, a rigorous yet flexible approach which demands reflexivity and transparency from the researcher. I followed the steps outlined by Tweed and Charmaz (2012) which involved a process of coding, categorising, constant comparison, and theoretical sampling. This approach pushed me to seek multiple, and at times conflicting, accounts from participants with various experiences to generate a comprehensive theoretical framework. However, while my participants described complex and circuitous routes to recovery, these were conveyed through a single telephone interview. While I purposively

interviewed people at various stages of change and use of the site, it would be helpful to follow individuals' recovery journeys over time.

Caution is needed in generalising these findings to other populations, or to other online groups for alcohol or different addictions. I did not intend to recruit a representative sample of people who access online support groups but chose instead to explore the views and experiences of members and browsers of one group to develop theory as to how involvement in the group may effect change. Consequently, this resulted in the development of a theory guided by narratives that were clearly influenced by the *Soberistas* ethos and therefore uniform in nature. However, given the scarcity of research in this area, and the increasing popularity of Internet-based self-support, my findings may deepen understanding of how engagement with online mutual aid might facilitate recovery, highlighting its role in identity (re)construction processes. By situating the findings within the broader recovery literature, the data may have relevance beyond this sample, and raises questions for future research (including the development of later studies presented within this thesis).

It is important to note that the sample was rather homogeneous, comprising mainly professional, white women who were nested within a family unit. While the aim of this study was not to examine the role of gender in use of online mutual aid, some research has found that the processes underlying change might differ between men and women. For example, White and Chaney (1992) suggest that men often require a pivotal 'turning point' experience that results in feelings of powerlessness and compels them to turn to powers outside of their control, while women may be more inclined to find power from within themselves. Therefore, it may not be a coincidence that the membership base of *Soberistas*, with its healthy-living approach to giving up alcohol and emphasis on 'taking control', is predominantly female (Sinclair, Chambers and Manson, 2016). The group name, *'Soberista'*, with its female-gendered connotations, may also contribute to this bias. Further research is therefore needed to explore the role of gender in use of online mutual aid, specifically in relation to identity change in recovery.

4.8.2   Conclusions

The use of qualitative methods provides insight into how this sample used a non-12-step orientated online mutual aid group to address problematic alcohol use. Online groups appear to provide an alternative for people who experience barriers to accessing traditional services and may serve as a platform for exploration in those at early stages of change. Clinicians in non-alcohol-specialist services might consider signposting to such groups which require no commitment on behalf of the client.

My findings extend literature that implicates a role for identity change in recovery, and highlight how engagement with Internet-based groups may help facilitate this. Importantly, participants described arriving at a stage of wanting to change behaviour before they experienced any significant life-changing consequences of their drinking; they were keen to protect their "normal" lives, defined by stable employment, relationships and health, and problematic alcohol use put this in jeopardy. Because of the secrecy surrounding their drinking, participants also had the freedom to choose how they made sense of, and defined, this behaviour – lack of contact with treatment services and healthcare professionals meant they avoided labels such as 'alcohol use disorder' or 'alcoholic'; analysis suggested this freedom was an important mechanism underpinning participants' willingness and ability to change.

SECTION 2: A MIXED-METHODS OBSERVATIONAL COHORT STUDY OF PATIENTS WITH ALCOHOL USE DISORDERS ATTENDING HOSPITAL

Chapter 5   METHODS

5.1   Introduction

Study 1 (*Soberistas*) was a cross-sectional study, limiting what could be understood of participant recovery journeys to a single interview. Moreover, having recruited from one mutual aid group, participants' conceptualisations of alcohol use and recovery were relatively homogeneous, in keeping with the *Soberistas* philosophy. A second study was therefore designed to gain greater understanding of a more diverse sample of participants in terms of their relationship with alcohol and recovery over time. While most general hospital patients with alcohol use disorders (AUD) are not in specialist alcohol treatment (Bertholet *et al.*, 2010; Freyer *et al.*, 2007; Owens *et al.*, 2016; Parkman *et al.*, 2017b; Rumpf, Hapke and John, 1998), their use of secondary care services and assessment by clinical staff, brings to the fore their problematic alcohol use, and the option of secrecy is removed. This contrasts with the experiences of *Soberistas* participants, many of whom never spoke of their problematic drinking, and so provided an opportunity to explore identity and change processes in a different population.

A longitudinal observational study, which recruited patients with alcohol use disorders (AUD) presenting to hospital, comprised two phases:

- **Phase I:** Quantitative interviews with a cohort of participants recruited during their baseline hospital attendance/admission, and again six months later.
- **Phase II:** In-depth qualitative interviews with a subsample of participants who completed both interviews in Phase I and who were willing to discuss their experiences of problematic alcohol use, hospital attendance, and recovery in more detail.

Section 5.1.1 on Page 85 outlines the specific research questions within each phase.

In the design of this study, I aimed to recruit a sizeable cohort of individuals with wide-ranging characteristics and experiences, helped by liberal inclusion criteria, to generate theory about the complexities of living with and beyond a problematic relationship with alcohol. Investigation of patient demographics, drinking patterns, and other quantitative variables, provided contextualisation for the narratives garnered during in-depth interviews; it also facilitated purposive selection of a maximum-variation sample of participants for the qualitative phase. The methods for both phases are presented in this chapter; quantitative results can be found in Chapter 6, and qualitative results in Chapters 7-9.

Beyond describing the characteristics and drinking profile of the cohort, I aimed to assess participant trajectories in the six months following discharge from hospital; variables examined for change (or lack thereof) included alcohol consumption (quantity and frequency), psychological dependence, psychological distress, and readiness to change. In addition to assessing statistical difference, changes in psychological dependence were examined to assess whether participants had demonstrated *clinically significant and reliable* change (CSC), as per Jacobson and Truax's (1991) guidelines. This analysis is helpful when exploring change in clinical populations, as statistically significant effects may not be clinically meaningful (and statistically non-significant effects may be). Psychological dependence, as measured by the Leeds Dependence Questionnaire (LDQ), was chosen for this analysis for three main reasons:

1) My qualitative analysis (Phase II) identified that levels of psychological dependence were often more significant in participants' conceptualisation of their relationship with alcohol, and had a greater impact on wellbeing, functioning, and identity, than actual levels of consumption (Chapter 7). Moreover, in keeping with other findings (Tober, 2000), several participants in my study reported that dependence persisted during recovery, and this was usually described as a negative experience (Chapter 9). It therefore seemed pertinent to understand the degree of CSC in the level of psychological dependence within the cohort.

2) The LDQ assesses both beliefs and behaviours associated with dependence and is sensitive even during periods of abstinence; given point (1) above, it was important to be able to detect manifestations of dependence beyond alcohol consumption and physical symptoms of tolerance and withdrawal.

3) Normative data were available with which to calculate CSC (Raistrick *et al.*, 2014).

While it is useful to explore the nature of change in various behaviours/characteristics over time, it is also helpful to identify predictors of change. Prediction of outcome allows us to identify who might have poorer outcomes, improve the accuracy of prognosis, and develop targeted interventions (Adamson, Sellman and Frampton, 2009). This is particularly important when considering care of medical inpatients with AUD, as the evidence base for the efficacy of interventions in this setting is limited (Glass *et al.*, 2015; McQueen *et al.*, 2011; Mdege *et al.*, 2013; Simioni, Cottencin and Rolland, 2015). Understanding who demonstrated un/favourable outcomes at six months therefore became an important aim of the study. Given the above, predictors of CSC in dependence were assessed, in addition to alcohol consumption at six months. As recommended by Field (2009), selection of quantitative predictor variables was informed by previous research, and guidance for assessing/monitoring patients with AUD in clinical practice e.g. (NICE, 2011). However, as there is limited evidence for predictors of outcome among medical

inpatients (Bertholet *et al.*, 2010), I also explored research conducted with general and treatment-seeking populations, e.g. (Adamson, Sellman and Frampton, 2009; Moss, Chen and Yi, 2007). Moreover, my own qualitative data informed inclusion of some variables, in keeping with a mixed-methods grounded theory approach to understanding participant experiences.

5.1.1   Research questions

1) What are the personal characteristics and drinking profile of a cohort of patients with AUD presenting to one general hospital? [results: Chapter 6, Section 6.3]

2) What is the role and acceptability of hospital-based interventions for individuals with problematic alcohol use? [see Chapter 6, Section 6.3.3 for quantitative findings & Chapter 8 for qualitative narratives]

3) What is the trajectory of participant recovery journeys during the six months following a hospital attendance or admission? [results: Chapter 6, Section 6.4]

   a. Do more participants engage in specialist alcohol treatment post hospital discharge?
   b. What changes do participants make in their drinking behaviour, psychological dependence on alcohol and other related variables (including readiness to change and depression/anxiety symptoms)?
   c. How many participants demonstrate CSC in level of psychological dependence?
   d. Does the change in number of heavy drinking days differ according to characteristics measured at baseline?

4) What baseline variables predict alcohol-related outcomes (see i. and ii. below) six months after hospital attendance or admission? [results: Chapter 6, Section 6.5]
   i. Primary outcome: alcohol consumption (heavy drinking days, HDDs)
   ii. Secondary outcome: CSC in psychological dependence

5) How do participants conceptualise and define their identity in relation to their use of alcohol and if applicable, their recovery? [results: Chapters 7-9]

6) What is the impact of a hospital attendance or admission on participants' sense of self and relationship with alcohol? [results: Chapters 8 & 9]

5.2   Methods

5.2.1   Study design

Figure 5 depicts the study design, briefly outlined above.

Figure 5:   Mixed-methods hospital cohort study design

5.2.2   Sample size

5.2.2.1   Phase I: Quantitative cohort

Statistical advice was obtained from a statistician from the University of Southampton. A power calculation was conducted to provide an indication of possible statistical generalisation from a relatively small sample. The value of doing so permits inferences about the characteristics of a wider set of individuals who met inclusion criteria for the study but were not recruited (i.e. patients seen by the same clinical teams during a similar period of time at Southampton General Hospital).

The power calculation was based on detecting the effect of a baseline predictor on the change in number of drinking days at follow-up. This main objective was to get a better understanding of what can be inferred from a patient's baseline characteristics in relation to the patient's drinking trajectory at six months. This is operationalised in the form of an independent means two-tailed equal variance *t*-test of the change in drinking days at follow-up. The power level was set to 80% (beta=.2) with a confidence level alpha=.05, and the minimum meaningful difference to be detected was a difference of one day in the change in drinking days at follow-up. Evidence from previous research with heavy drinkers (n=172) in a general hospital setting (Holloway *et al.*, 2007) found a standard deviation in the reduction in number of drinking days per week of approximately 1.7. Assuming equal size of the groups to be compared (for instance: low vs. moderate-high psychological dependence, in alcohol treatment vs. not in treatment at baseline), the sample size required to achieve the desired power level was 94. If the size of one group is twice the size of the other group, the overall sample size required rises to 106. The latter sample size was used as the main target and adjusted for predictable loss to follow-up. Longitudinal studies with similar populations report between 15-50% attrition after six months, e.g. (Cobain *et al.*, 2011; Holloway *et al.*, 2007; Owens *et al.*, 2016; Rochat *et al.*, 2004). To reach the sample size of 106 with an assumption of 25% attrition, the target recruitment size was a minimum of 142 (see Section 6.2 in Chapter 6 for full details of participants recruited into the study).

5.2.2.2   Phase II: Qualitative in-depth interviews

As discussed in Chapter 3, sample size in a grounded theory study is determined by theoretical saturation. However, considering time and financial constraints, and to satisfy ethics committees who require information about the expected number of participants, I proposed that up to 30 interviews would be conducted. This provided sufficient scope to explore a range of experiences and views but was feasible within the context of a PhD project.

5.2.3   Study site and access

The study took place at Southampton General Hospital, the largest site within University Hospital Southampton (UHS) NHS Foundation Trust. The number of alcohol-related admissions to the hospital is high, with figures increasing over recent years (PHE, 2018a). Admissions are particularly high for males; in 2016/17, for example, there were 1041 per 100,000 hospital admissions related to alcohol (narrow measure) in men, compared to the South East of England average of 680 per 100,000, and the UK national average of 818 per 100,000 (PHE, 2018a). Even when taking female admissions into consideration, Southampton had the highest number of alcohol-related

admissions per 100,000 in the South East Region and ranked 28/148 UK regions where data were available.

During recruitment for the study, there were significant changes to the configuration of service delivery at the hospital, such that patients with AUD were no longer referred to and assessed by a single Alcohol Care Team (ACT). Consequently, recruitment was broadened to include patients seen by any member of clinical staff, including staff within the ACT, the Vulnerable Adult Support Team (VAST) based within the emergency department (ED), and the liaison psychiatry team. These teams typically support individuals with significant socio-psychological needs including those related to domestic violence, homelessness, mental illness, and substance use.

5.2.4 Research ethics

Efforts were made to identify and manage any potential ethical issues before the study began. As the study involved interviewing patients within a vulnerable population, it was imperative to conduct the study sensitively. I met with key members of staff based at the hospital who might be involved in recruitment (e.g. nurses, support workers, and managers) and presented the research proposal prior to submitting for ethical review. Their input guided the implementation and conduct of the study, and early communication with clinical staff encouraged a positive working relationship. I also met with the Lay Expert Panel (LEP) of the Wessex Alcohol Research Collaborative (WARC) to gain their feedback on study documents including the Participant Information Sheet and Consent Form.

5.2.4.1 Ethical approval

The University of Southampton acted as sponsor for both the quantitative cohort study (Phase I) and the qualitative interview study (Phase II). Separate ethics applications were submitted for each phase (see details in Table 3). Approval was first granted by an NHS research ethics committee (REC), then by the Health Research Authority (HRA), and finally the Research and Development (R&D) department at UHS. Approval letters for original ethics applications can be found in Appendices H (phase I) and I (phase II).

A substantial amendment was requested and approved by the same ethics committee for Phase I, which broadened the recruitment strategy to permit referrals from multiple clinical teams. Two later non-substantial amendments were requested and approved to allow continued access to participants' hospital records for data collection purposes.

Table 3:   Details of ethics approvals

Phase	Reference numbers	Details of ethics approvals
I: Quantitative cohort	IRAS: 204165 Northern Ireland REC: 16/NI/0100	REC: 03/06/2016 HRA: 19/08/2016 UHS R&D: 30/08/2016 Amendment 1: 07/11/2016 (UHS R&D) Amendment 2: 30/10/2017 (UHS R&D) Amendment 3: 02/05/2018 (UHS R&D)
II: Qualitative interviews	IRAS: 219964 East of Scotland REC: 17/ES/0005	REC: 15/02/2017 HRA: 15/02/2017 UHS R&D: 30/03/2017

REC: Research Ethics Committee; **IRAS**: Integrated Research Application System; **HRA**: Health Research Authority; **UHS R&D**: University Hospital Southampton Research and Development

5.2.5   Eligibility

Many hospital-based alcohol studies exclude alcohol-dependent individuals or those with dual-diagnoses, including substance use disorder and other psychiatric disorders (McQueen *et al.*, 2011; Mdege *et al.*, 2013; Simioni, Cottencin and Rolland, 2015). However, my inclusion criteria were deliberately broad with the intention to recruit a diverse cohort of individuals with varying levels of alcohol consumption, dependence, and treatment history, who are more representative of patients presenting to this setting. Thus, inclusion criteria for **Phase I** were:

- Patients who reported hazardous, harmful, or dependent drinking patterns, identified routinely during their hospital attendance or admission by clinical staff (all patients referred to the study had an Alcohol Use Disorder Identification Test (AUDIT) score ≥8)
- Patients, male or female, who were ≥18 years old

Exclusion criteria for **Phase I** were:

- Patients who were unable to give informed consent, perhaps due to acute intoxication or cognitive impairment*
- Patients who were acutely unwell or distressed*
- Patients who did not speak English and would require the assistance of a translator

*Hospital staff made a clinical judgement about patient suitability for the study before gaining their initial consent for me to visit.

Inclusion criteria for **Phase II** were:

- Participants who had completed both baseline and follow-up interviews in Phase I
- Participants who had initially consented to be contacted about involvement in further research at baseline, or later expressed interest in taking part in a qualitative study

Exclusion criteria for **Phase II** were:

- Participants who were unable to give informed consent, perhaps due to acute illness, distress, or intoxication.

Eligible participants were invited for interview in keeping with maximum variation and theoretical sampling principles (see Chapter 3).

5.2.6 Phase I: Data collection and procedure

Two research medical students (a Master's student and a Year 3 student during their research placement) assisted with data entry and patient interviews[4] under supervision. Training was provided to ensure uniformity in interview format, administration and scoring questionnaires, and data input.

The researcher(s) only approached patients who had first been informed of the study by a clinical member of staff (see Appendix J for Participant Information Sheet). As many patients have short stays in hospital, particularly within ED, the researcher(s) visited patients shortly after being identified as suitable to gain informed consent (see Appendix K for Consent Form). However, patients were afforded longer periods of time to consider participation if they wished.

Patients were first interviewed during their hospital attendance or admission, or shortly after discharge if their hospital stay was particularly short. Most interviews were conducted on hospital wards, with attention paid to ensuring privacy and discretion. The research team administered a series of questionnaire measures (see 5.2.6.1 below) which took approximately 25 minutes to complete. However, it was important for participants to feel relaxed and not rushed, and so

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[4] In the event, I was present during all but two baseline interviews, and every follow-up interview.

interview length varied; some interviews were conducted over two sessions due to participant ill-health, or interruptions for medical interventions or family visits.

Participants were contacted again six months after baseline interview (allowing for a 2-week window either side of this date). The same questionnaire measures, except the "Participant Information Questionnaire" (see 5.2.6.1 below), were repeated, and participants were reimbursed £10 for their time, plus any travel costs. Follow-up interviews took place at College Keep Academic Centre (the University Department of Psychiatry), Southampton General Hospital, over the phone, or occasionally at the participants' home address, after an appropriate risk assessment.

If participants did not respond to three contact attempts, hospital records were accessed to check if they were in hospital or had passed away. I also contacted GPs, but only if participants had provided written consent for this at the start of the study. These information requests were made prior to contacting locators (typically family/friends) to avoid causing unnecessary upset. The death certificates of individuals who were confirmed as deceased were then requested via the General Register Office website.

5.2.6.1 Measures

It was important to select measures for which previous research has supported their use with an AUD population, demonstrated reliability to measure the construct of interest, and known to be sensitive to change over time. The range of variables measured include many of those recommended by the National Institute for Health and Clinical Excellence (NICE, 2011) for the assessment of adults requiring treatment for problematic use of alcohol. However, a key consideration was to keep the interview as short as possible; this became particularly pertinent for interviews conducted in ED. Consequently, some questionnaires were selected over others measuring similar constructs because of their relative brevity.

Participant Information Questionnaire (Appendix L)

A purpose-designed questionnaire captured basic information about participants' socio-demographic characteristics, current and recent use of specialist alcohol services, and details of the current hospital admission (e.g. reason for attendance/admission, history of alcohol use, assessments/interventions in a secondary care setting). Participants were also asked to rate their confidence in changing their drinking behaviour (i.e. level of self-efficacy). The questionnaire included fixed tick-box options, Likert scales to rate discussions of alcohol use in hospital and

confidence in changing behaviour, and space for additional comments. Participants were encouraged to talk around their responses if they wished, and the researcher made notes where relevant. Each interview began with this questionnaire to encourage general discussion about the person and put them at ease.

Subsequent standardised assessment scale measures focused specifically on alcohol-related behaviours and other variables of interest:

Alcohol Use Disorder Identification Test *(AUDIT, Saunders et al., 1993)*

The AUDIT is a formal screening tool for hazardous and harmful drinking patterns (NICE, 2011). It is comprised of 10 questions, each scored 0-4. Categories of risk in relation to alcohol consumption may be defined by AUDIT scores with hazardous drinkers scoring 8-15, harmful drinkers scoring 16-19 and scores of 20+ indicative of possible dependence. Items cover three areas: alcohol consumption, alcohol-related harm, and symptoms of alcohol dependence. The first three questions (alcohol consumption questions) form a shortened screening test, often used in busy clinical settings, called the AUDIT-C. The AUDIT's sensitivity and specificity are well documented in the literature, and it has been validated in a range of clinical populations, including medical inpatients (Bohn, Babor and Kranzler, 1995; de Meneses-Gaya *et al.*, 2009). Two reviews of research into the AUDIT found it to be practical, have good internal consistency, short- and intermediate-term (2-6 week) stability, and perform as well as, if not superior to, other scales (Reinert and Allen, 2002;2007). For comparability with length of follow-up, I used the AUDIT to assess drinking patterns in the past six months. The AUDIT demonstrated acceptable internal consistency in the present study ($\alpha = 0.77$).

Leeds Dependence Questionnaire *(LDQ, Raistrick et al., 1994)*

The LDQ can be used as a measure of dependence on alcohol (NICE, 2011) during periods of drinking or abstinence and is sensitive to change over time (Raistrick *et al.*, 1994). It focuses on the psychological (rather than physiological) concept of dependence, which is considered a key driver in substance use and an important indicator of prognosis (Fairhurst *et al.*, 2014). The LDQ has 10 items scored 0-3, with higher scores indicative of more severe dependence. Scores can be dichotomised as low (0-10) vs. moderate-high (11-30) levels of dependence.

The 10 items measure 10 markers of dependence present in the past 2-weeks: preoccupation, salience, compulsion to start, planning, maximise effect, narrowing of repertoire, compulsion to continue, primacy of effect, constancy of state and cognitive set. The LDQ is found to be reliable for use in a variety of settings, e.g. (Fairhurst *et al.*, 2014; Ford, 2003; Heather *et al.*, 2001), has high internal consistency ($\alpha = 0.92$ when alcohol is the primary problem substance (Heather *et al.*,

2001), and high test re-test reliability over a 2-5 day period (r = 0.95, (Raistrick *et al.*, 1994). The LDQ demonstrated excellent internal consistency in the present study (α = 0.93).

The 7-day Timeline Follow Back *(TLFB, Sobell and Sobell, 1992)*

The TLFB method is a self-report drinking assessment method that obtains estimates of daily drinking over a specific time period before the interview date (typically ranging from 30 days to three months). The alcohol TLFB has been shown to have good psychometric properties when used with a variety drinking populations and is found to be generally reliable (Sobell and Sobell, 1992). To minimise the impact of poor memory recall and in the interest of brevity, the 7-day TLFB was used in this study to measure consumption in the 7 days prior to hospital admission. This shortened version of the TLFB has been used in several other studies with a similar population, e.g. (Black, Gill and Chick, 2011; Chick, Lloyd and Crombie, 1985; Holloway *et al.*, 2007; Liu *et al.*, 2011; McManus *et al.*, 2003), and is considered more accurate on a fine-grained scale than TLFB assessments covering longer periods of time (Hoeppner *et al.*, 2010). Total number of weekly units were calculated, in addition to the number of drinking days (DDs) and heavy drinking days (HDDs, defined as per European Medicines Agency (2010) guidelines of >40g or 5 UK units of alcohol for women, and >60g or 7.5 UK units for men).

Stages of Change Readiness and Treatment Eagerness Scale *(SOCRATES, Miller and Tonigan, 1996)*

The original SOCRATES is a 19-item instrument assessing current readiness for change in problem drinkers (Miller and Tonigan, 1996), and aims to measure stages of change ('precontemplation', 'contemplation' and 'action') described by Prochaska and DiClemente (1983). Examination of the psychometric properties of the questionnaire in non-treatment-seeking medical inpatients supported a two-factor structure ('problem perception', 10 items and 'taking action', 6 items) rather than the original three-factor structure (Bertholet *et al.*, 2009a), and was therefore used in the present study. The reduced component structure corroborates work with other non-treatment seeking populations, e.g. (Burrow-Sanchez, 2014; Maisto *et al.*, 1999).

The two components are scored on a 5-point Likert scale and yield continuous scores, with higher scores indicating greater readiness. The 'problem perception' scale (score range 10-50) measures problem awareness and recognition of the need to access help to change drinking; the 'taking action' scale (score range 6-30) assesses steps the individual has taken, or is currently taking, towards addressing their drinking problem (Bertholet *et al.*, 2009a). The two-factor scale has good internal consistency (Bertholet *et al.*, 2009a), corroborated by my data (overall scale α = 0.86; 'Problem Perception' scale α = 0.85; 'Taking Action' scale α = 0.91). The 16-item version has been

employed in subsequent research with hospital inpatients, e.g. (Bertholet *et al.*, 2010; Bertholet *et al.*, 2009b; Clark *et al.*, 2012; Williams *et al.*, 2010).

Hospital Anxiety and Depression Scale *(HADS, Zigmond and Snaith, 1983)*

The HADS is a 14-item scale that determines the level of anxiety and depression that a patient has experienced during the past week. It was devised for use in a general medical population of patients (Zigmond and Snaith, 1983). There are two subscales, one for anxiety and one for depression, each comprising 7 questions (score 0-3). Scores for the entire scale range from 0 to 42 with higher scores indicating more psychological distress. A cut-off score of 8/21 has been proposed to determine possible or probable 'caseness' of anxiety and depression in non-cancer medical patients (Bjelland *et al.*, 2002). The HADS has been shown to perform well in a variety of populations (Bjelland *et al.*, 2002; McPherson and Martin, 2011), although research favours its use as a continuous measure of psychological distress (Cosco *et al.*, 2012). The HADS demonstrated excellent internal consistency reliability in the present study ($\alpha = 0.92$).

5.2.6.2   Additional data collection

Participants also provided consent for researchers to access their hospital (medical) records for the duration of the project. Relevant information was recorded, including details of the patient's current hospital admission (length of stay, reason for attendance/admission).

5.2.7   Phase II: Data collection and procedure

After completion of both baseline and six-month follow-up interviews, a subsample of participants was invited to take part in a further qualitative interview to explore their experiences of alcohol use, recovery, and hospital attendance/admission in more detail (see Appendices M and N for Participant Information Sheet and Consent Form). I conducted interviews in person, usually at College Keep Academic Centre (the University Department of Psychiatry), or occasionally at the person's home address[5]. Interviews lasted between 40-181 minutes (*Mean* = 105) and were audio-recorded with permission. Participants were reimbursed £10 for their time, plus any travel costs.

While a topic guide (Appendix B) ensured I covered the main areas of interest, participants were encouraged to 'take the lead' and discuss what was important to them. I also referred to participants' quantitative data to stimulate discussion around the impact of a hospital

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[5] Medical student researchers did not shadow/conduct any qualitative interviews.

attendance/admission on their drinking behaviour and other measured variables. I frequently asked participants to elaborate on their responses to certain questionnaire items (e.g. *"I am an alcoholic"* from the SOCRATES; *"Do you find it difficult to cope with life without alcohol?"* from the LDQ), or to discuss their thoughts about why certain questionnaire scores changed (or not) from baseline to follow-up. Qualitative discussion around quantitative measures gave participants a voice and added depth to the findings from Phase I. Additionally, I incorporated some questions based on items from measures currently being used in alcohol research, which purportedly assess the extent and strength of an individual's alcohol-related identity. For example:

- *"How important is drinking to who you are as a person?"* – single item measure to assess 'drinking identity strength' (Lindgren *et al.*, 2016)
- *"Is drinking part of 'who you are'?"* – adapted from the Smoker's Self-Concept Scale (Shadel and Mermelstein, 1996), used in research by Lindgren and colleagues (2013)
- *"Are you proud to be a drinker?"* – item used to assess 'explicit drinker identity' (Frings, Melichar and Albery, 2016)

I did not include these items/measures within the wider cohort study as I found little evidence for the appropriateness of their use with clinical AUD populations. Instead, I used them in an exploratory manner during qualitative interviews to elicit insights about the concept of alcohol/recovery identity. The use of a graphic task, completed during every interview, aided this exploration:

Pictorial Representation of Illness and Self Measure Revised version *(PRISM-R, Wouters et al., 2008)*

The PRISM is considered a measure of the "burden of suffering due to illness" which captures the intrusiveness of the illness on self, and perceived controllability over the illness (Büchi *et al.*, 2002; Büchi *et al.*, 1998). It has been used in research of various conditions including rheumatoid arthritis (Büchi *et al.*, 1998) and systemic lupus erythematosus (Büchi *et al.*, 2000) and has been employed successfully with individuals with alcohol dependence (Bischof *et al.*, 2016; Reinhardt *et al.*, 2006). The PRISM has been found to be a reliable and consistent tool which yields personally salient information and has the potential for wide application (Sensky and Büchi, 2016).

The task involves an A4-sized piece of paper displaying a large circle, representing the person's life as it is presently (see Figure 6). Inside the large circle is a fixed yellow circular disc representing the person's 'self', and there are three additional loose red discs of various sizes representing their 'illness', in this case AUD. The participant is asked to choose one of the three different sized 'illness' discs (smaller than, equal to, or larger than the 'self' disc), and place it somewhere on the

page to indicate the importance of alcohol in their life. Buchi and colleagues (1998) suggest that placement of the 'illness disc' *over* the 'self disc' may represent a threat to an individual's sense of self and identity, while a larger separation between illness and self might indicate more healthy adjustment.

While a quantitative outcome can be obtained by measuring distances between the self and illness discs (as reported in already-published alcohol studies), I was more interested in the ability of this task to yield qualitative data by encouraging discussion with participants about their drinking in relation to self. Participants were encouraged to talk around the impact of a hospital admission on their drinking behaviour, and whether this event shaped their identity in relation to alcohol. They were able to use the discs freely if it helped aid discussion of their drinking and sense of self over time.
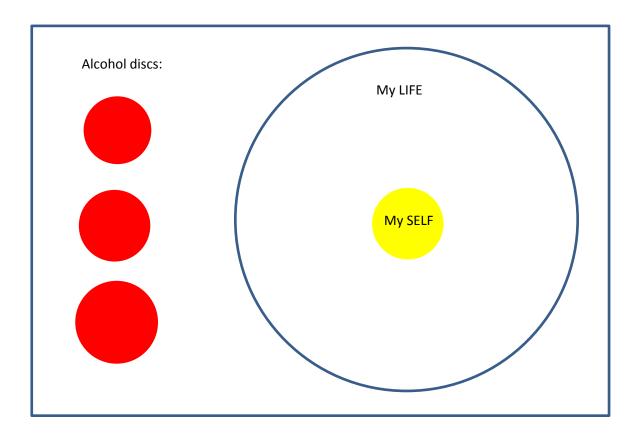
Figure 6:   Revised PRISM task

5.2.8   Quantitative data analysis

As the steps to analyse qualitative interview data have already been described in detail in Chapter 3, this section focuses only on analysis of quantitative data collected during Phase I. An overview of the statistical analyses is presented here; additional information, where relevant, can be found within corresponding sections of the result chapter (Chapter 6).

Data were inputted into IBM SPSS Statistics 24.0 for analysis, after being checked for completeness and accuracy. As the researcher conducted interviews alongside participants, completed questionnaires contained no missing data. Prior to analytic testing, distributions of the data were examined using both numerical (skewness and kurtosis values, Shapiro-Wilk test) and graphical (Normal Q-Q plots, histograms, box-plots) methods. This informed decisions about how to handle and analyse data that were not normally distributed (discussed in the relevant sections below).

Longitudinal analyses between baseline (T1) and follow-up at six months (T2) were based on observed cases (n=121). Data are presented to a maximum of two decimal places, except for *p*-values where additional decimal places are necessary to highlight specific levels of significance. Significance was accepted as an alpha level of 0.05 or lower. Due to the exploratory nature of the research, all tests were two-tailed, and *p*-values were not adjusted for multiple comparisons. However, exact *p*-values, and where relevant, 95% confidence intervals (CI) and effect sizes/odds ratios are presented for transparency and to enhance interpretation of findings. Cohen's *d* is presented as a measure of effect size (where .2=small, .5=medium and .8=large effects) (Cohen, 1988).

The specific tests used at each stage of the analysis are as follows:

5.2.8.1 Descriptive analysis of the cohort (research questions 1 & 2)

Participant characteristics, their drinking behaviour, and other related variables at baseline were explored using simple descriptive statistics. Mann-Whitney U tests were conducted to compare the (continuous variable) characteristics of participants who were lost to follow-up with those who completed the study; Chi-square tests, or Fisher's exact test for cells with expected counts <5, were conducted for categorical variables.

5.2.8.2 Prospective trajectory of drinking behaviour and related variables (research question 3)

Research Question 3a: Simple descriptive statistics summarised participants' use of treatment following hospital discharge. Measures of central tendency and dispersion are presented as per the distribution of the data (i.e. means/standard deviations (SD) for normally distributed data and medians/inter-quartile ranges (IQR) for non-normal data).

Research Question 3b: Paired sample *t*-tests assessed the statistical changes (if any) between baseline and six-month follow-up point in the cohort's mean level of alcohol consumption, psychological dependence, readiness to change and psychological distress.

Although the distribution of the differences in some variables were not normally distributed, *t*-tests were employed as they are robust to violations of normality in samples that are "sufficiently large", ~100 (Lumley *et al.*, 2002)[6]. For information, median change scores (with IQR) are presented in Appendix O.

Research Question 3c: In addition to assessing statistical difference, changes in psychological dependence (LDQ score) were examined to assess whether participants had demonstrated *reliable and clinically significant change* (CSC), as per Jacobson and Truax's (1991) guidelines. Participants could then be classified as either demonstrating: 1) reliable and clinically significant change (i.e. a favourable outcome), or 2) no change/reliable deterioration (i.e. an unfavourable outcome).

Firstly, scores were examined for reliable change, which is said to have occurred when the degree of change is sufficiently large enough to conclude it is unlikely to be because of measurement unreliability. There are three possible reliability outcomes, and the number of participants demonstrating each were calculated:

- Reliable deterioration
- No reliable change
- Reliable improvement

The formula to calculate reliable change proposed by Jacobson and Truax (1991) is:

$$Reliable\ change = \frac{x_2 - x_1}{S_{diff}}$$

where x_1 represents a participant's pre-test score, x_2 represents a participant's post-test score and S_{diff} is the standard error of the difference between the scores. S_{diff} can be calculated from the standard error of measurement (S_E) according to the formula:

$$S_{diff} = \sqrt{2(S_E)^2}$$

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[6] NB: the same pattern of results was found when non-parametric Wilcoxon signed-rank tests were conducted.

Standard error is calculated as:

$$S_E = {}^{S_1}\!\sqrt{1 - r_{xx}}$$

where r_{xx} is the test re-test reliability of the measure (reported as 0.95 in the LDQ validation study (Raistrick *et al.*, 1994), and S_1 is the standard deviation for the mean total LDQ score for the cohort at baseline (10.29). Therefore, S_E was calculated to be 2.30, and S_{diff} to be 3.25. A reliable change score could then be calculated for each participant; Jacobson and Truax (1991) propose that a score ≥1.96 is unlikely to have occurred by chance (this translates to a minimum score change of 7 points on the LDQ in the current study).

Next, to establish which participants had demonstrated CSC, a cut-off LDQ score was calculated by summing the mean of the 'dysfunctional' clinical sample (i.e. participants in my cohort) and the mean of a 'well-functioning' normative sample (weighted average mean combining scores of males and females, taken from Raistrick et al. (2014); n=817 opportunistic NHS and local university sample) and dividing by two[7]:

(Mean of clinical cohort, 18.43) + (Mean of normative sample, 2.95) / 2 = 10.7

As the cohort's LDQ scores at baseline were negatively skewed (median = 22, mean = 18.43), using the mean resulted in a more stringent cut-off. Participants whose LDQ scores reduced to below the cut-off at follow-up (i.e. 10.7) were considered to have made CSC as their level of dependence moved closer to that found within a well-functioning population. To be considered as having demonstrated a favourable outcome in levels of psychological dependence, participants had to display *both* reliable *and* clinically meaningful change.

Research Question 3d: The a priori power calculation was based on detecting the effect of baseline characteristics on the change in number of drinking days (DDs) at follow-up, drawing on data from previous research with heavy drinkers in a general hospital setting (Holloway *et al.*,

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[7] The same cut-off score was used for males and females as there was no difference between their baseline LDQ scores (*M* = 18.46 and 18.34 respectively); *t*(139) = -.062, *p* = .951.

2007); see Section 5.2.2. However, there was large disparity in alcohol consumption between my sample and Holloway et al.'s at baseline (median weekly unit consumption in my study was 112.5 and median number of drinking days was 7, compared to Holloway et al.'s study of 35 units and 3 drinking days). After discussion with a statistician and my supervisory team, I decided instead to assess the change in number of *heavy* drinking days (HDDs, as per European Medicines Agency (2010) guidelines) from baseline to follow-up; this is a more realistic marker of clinical progress, and often preferred treatment goal, in patients with alcohol dependence (Gastfriend *et al.*, 2007; Mann, Aubin and Witkiewitz, 2017; Witkiewitz *et al.*, 2017), and is now recognised by medicines development guidance authorities as a viable trial endpoint (European Medicines Agency, 2010; Food and Drug Administration, 2015). Independent samples *t*-tests were employed to examine the mean change in number of HDDs (T2 – T1), according to the following baseline characteristics:

Socio-demographics
- Gender (male vs. female)
- Relationship status (in a relationship vs. single)
- Living situation (living with others vs. living alone)
- Employment status (employed/education vs. not in work)
- Smoking status (smoker vs. non-smoker)
- Known familial alcohol use disorder (yes vs. no)
Alcohol-related[8]:
- Baseline alcohol treatment engagement (yes vs. no)
- Psychological dependence (moderate-high vs. low LDQ score)
- Problem perception (high vs. low SOCRATES subscale score, median split)
- Taking action (high vs. low SOCRATES subscale score, median split)
Hospital-related:
- Direct alcohol-related admission (yes vs. no)
- Assessment of alcohol use in secondary care setting (first assessment vs. previous assessment history)
- Context of hospital attendance (emergency department vs. inpatient admission)
Psychological distress:
- Depression symptoms (case vs. non-case as per HADS score)
- Anxiety symptoms (case vs. non-case as per HADS score)

For information, median change scores (with IQR) are presented in Appendix P.

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[8] AUDIT scores were not included in these analyses as there was minimal variation in scores between participants (nearly 90% scored ≥20, indicative of probable dependence).

5.2.8.3   Predicting alcohol-related outcomes at six months (research question 4)

In exploratory analyses to build on those described in Section 5.2.8.2 above, regression modelling was employed to assess whether any baseline variables could predict outcomes at six months, after controlling for differences in baseline alcohol consumption (which is recognised as one of the strongest predictors of outcome in patients with AUD (Adamson, Sellman and Frampton, 2009; Peacock *et al.*, 2018). There were two outcomes of interest:

1. Alcohol consumption (heavy drinking days)

In keeping with the changed focus from DDs to HDDs given the high levels of alcohol dependence/consumption in my sample, the primary analysis aimed to assess baseline predictors of HDDs at six months using information from the 7-day TLFB. However, past-week HDDs data at six months exhibited a non-normal distribution, as assessed by visual inspection of both a Normal Q-Q Plot and Histogram (see Appendix Q) and confirmed by Shapiro-Wilk's test (*p*<.001). The data displayed significant positive skewness (with 45% of participants reporting zero HDDs at follow-up; *z* = 2.02, *p*<.05) and highly significant negative kurtosis (*z* = -3.78, *p*<.001). Attempts to transform the data did not result in a normal distribution.

Considering the above, and after discussion with a statistician and my supervisory team, the outcome data were dichotomised, and logistic regression analyses employed to assess which factors could predict the probability of having a favourable outcome at six months. A favourable outcome was regarded as no HDDs in the past week, and an unfavourable outcome ≥1 HDDs. This approach is clinically meaningful as heavy drinking is associated with specific risks for disease morbidity and mortality, negative consequences such as accidents and domestic violence, and increased healthcare costs (Aldridge *et al.*, 2016; Dawson, Li and Grant, 2008; Gastfriend *et al.*, 2007). It is also similar to approaches taken in other hospital-based studies of patients with AUD, e.g. (Bertholet *et al.*, 2010; Bischof *et al.*, 2012; Chick, Lloyd and Crombie, 1985; Freyer-Adam *et al.*, 2010).

2. Psychological dependence

Logistic regression modelling was employed to assess which baseline variables could predict who made clinically significant and reliable change in level of psychological dependence (i.e. a favourable outcome) vs. who made no change or got reliably worse (i.e. an unfavourable outcome). Participants were excluded from this analysis if their LDQ score was below the threshold (in this instance, 10.7) at baseline; as their level of dependence was already closer to that of the well-functioning population, it was not possible to demonstrate CSC.

As recommended by Hosmer et al. (2013), and employed in other longitudinal research with a similar population, e.g. (Bertholet *et al.*, 2010; Freyer-Adam *et al.*, 2010; Williams *et al.*, 2010), a stepped approach to model-building was taken to aid purposeful selection of predictors, and build the most parsimonious models:

Step 1: Prior to regression modelling, correlations were performed to assess the relationship between baseline variables (these can be found in Appendix R). Spearman's correlation was employed for continuous data, as assumptions were not met for a parametric equivalent; rank-biserial correlations were used when one variable was binary, and chi-square tests (with Phi values) for association were used when both variables were binary.

Step 2: Variables were assessed for their independent association with each outcome. A measure of baseline drinking (baseline AUDIT-C score) was included as a covariate in all models; to borrow Bertholet et al.'s (2010) terminology, I call these 'minimally adjusted models'.

Step 3: Factors independently associated with the outcome were included together in a multivariable regression model to generate the 'final models'. The Hosmer and Lemeshow goodness of fit test was used to examine model adequacy.

Nagelkerke's (pseudo) R^2 values are presented for each model as an indication of the explained variation in the dependent variable. Research data associated with these quantitative analyses can be accessed via the University of Southampton repository (DOI: 10.5258/SOTON/D0689).

Chapter 6   QUANTITATIVE RESULTS: SETTING THE SCENE

6.1   Introduction

This chapter presents the quantitative results of the observational cohort study outlined in Chapter 5. These findings aim to 'set the scene' for the qualitative narratives presented in later chapters by providing greater insight into participants' lives and their relationship with alcohol in the six months following hospital attendance/admission. This contextualisation overcomes a limitation of single interview studies which restrict what can be understood about participant recovery journeys (as was the case in Study 1 with *Soberistas* members/browsers, Chapter 4).

Although this chapter presents the results of quantitative analyses only, frequency tables displaying participant characteristics (demographics, drinking profile etc.) include figures for both the whole cohort *and* the qualitative sub-sample; this serves to demonstrate my effort in exploring narratives from participants whose characteristics and experiences reflect the broad range found within the wider cohort.

6.2   Participant recruitment

Figure 7 displays the flow of participants through the study. A total of 144 participants were recruited during their hospital attendance/admission (referred to throughout as "index admission") between September 2016 and March 2017; three participants withdrew consent upon discharge, resulting in complete baseline datasets for 141 participants. Most participants were recruited via the hospital's Alcohol Care Team, ACT (n=88, 62.4%), with remaining referrals received from the emergency department based Vulnerable Adults Support Team, VAST (n=44, 31.2%), and staff from other clinical teams (n=9, 6.4%).

At six months, 132 participants (93.6%) were successfully followed-up. Of the nine lost to follow-up, eight were uncontactable and one declined to be interviewed again. There were no significant differences between those lost to follow-up (n=9) and those who completed the study (n=132) in any baseline characteristic (data not shown). Eleven participants had died before the six-month follow-up point, resulting in complete datasets at both time points for 121 participants (85.8%); those who had died and or were lost to follow-up (n=20) were more likely to be men, but they did not differ to the remaining cohort in any other measured characteristic (Appendix S). Due to the lack of difference between those who did and did not complete follow-up interview, longitudinal analyses were based on observed cases (n=121). In-depth qualitative interviews were conducted

with 26 participants who had completed both phases of the quantitative study (results are presented separately in Chapters 7-9).

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                        ┌─────────────────┐
                        │    n = 144      │
                        │  Participants   │
                        │   recruited     │
                        └─────────────────┘
                 ┌───────────────┴───────────────┐
        ┌─────────────────┐           ┌─────────────────┐
        │    n = 3        │           │    n = 141      │
        │   Withdrew      │           │   Completed     │
        │   consent       │           │   baseline      │
        └─────────────────┘           └─────────────────┘
                             ┌───────────────┴───────────────┐
                    ┌─────────────────┐           ┌─────────────────┐
                    │    n = 9        │           │    n = 132      │
                    │ Lost to follow- │           │  Followed-up at │
                    │  up at 6 months │           │    6 months     │
                    └─────────────────┘           └─────────────────┘
                                         ┌───────────────┴───────────────┐
                                ┌─────────────────┐           ┌─────────────────┐
                                │    n = 11       │           │    n = 121      │
                                │   Deceased      │           │   Completed     │
                                │                 │           │   follow-up     │
                                └─────────────────┘           └─────────────────┘
                                                                      │
                                                              ┌─────────────────┐
                                                              │    n = 26       │
                                                              │  Participated in│
                                                              │   qualitative   │
                                                              │    interview    │
                                                              └─────────────────┘
```
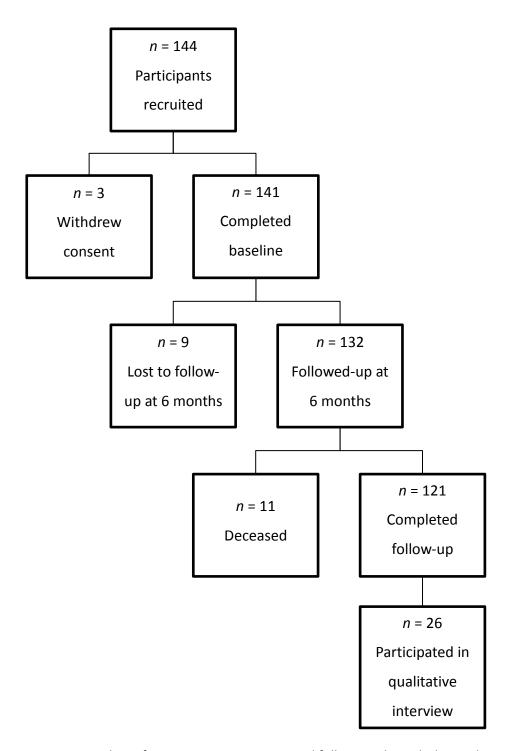
Figure 7:   Flow of participant recruitment and follow-up through the study

6.3 Cohort description (research questions 1 & 2)

6.3.1 Participant demographics

Table 4 provides a summary of the demographic characteristics of the cohort at baseline (T1). The majority of participants were Caucasian males, who lived alone and were currently registered long-term sick or disabled. Mean age was 50.8 years (SD = 13.67). Approximately half reported being aware of at least one first- or second-degree relative having an alcohol use disorder (AUD). Only a minority reported current gambling or illicit substance use (and of these, the vast majority described recreational cannabis use).

Table 4:   Participant demographics at baseline

Variable	Whole cohort n=141 n (%)	Qualitative sample n=26 n (%)
Gender		
Male	100 (70.9)	19 (73.1)
Age		
18 – 24 years	7 (5.0)	1 (3.8)
25 – 34 years	11 (7.8)	1 (3.8)
35 – 44 years	25 (17.7)	3 (11.5)
45 – 54 years	35 (24.8)	7 (26.9)
55 – 64 years	37 (26.2)	12 (46.2)
65+ years	26 (18.4)	2 (7.7)
Ethnicity		
Caucasian	134 (95.0)	26 (100.0)
Marital Status		
Married / in a relationship	34 (24.1)	5 (19.2)
Single / never married	66 (46.8)	12 (46.2)
Separated / divorced	37 (26.2)	8 (30.8)
Other (e.g. widowed)	4 (2.8)	1 (3.8)
Household Composition		
Lives alone	72 (51.1)	12 (46.2)
Lives with partner	21 (14.9)	5 (19.2)
Lives with child(ren) only	3 (2.1)	1 (3.8)
Lives with partner and child(ren)	12 (8.5)	0 (0.0)
Other (e.g. no fixed abode, student halls)	33 (23.4)	8 (30.8)
Occupation		
Employed or self-employed	21 (14.9)	5 (19.2)
Long term sick / disabled	66 (46.8)	13 (50.0)
Temporarily away from work	8 (5.7)	1 (3.8)
Unemployed	15 (10.6)	1 (3.8)
Retired	27 (19.1)	5 (19.2)
Other (e.g. homemaker, student)	4 (2.8)	1 (3.8)

Variable	Whole cohort n=141 n (%)	Qualitative sample n=26 n (%)
Highest Qualification		
University	13 (9.2)	2 (7.7)
Post-school leaving qualification / College	43 (30.5)	12 (46.2)
Secondary school (up to age 16)	70 (49.6)	11 (42.3)
Primary school (up to age 11)	10 (7.1)	0 (0.0)
None	5 (3.6)	1 (3.8)
Current smoker	88 (62.4)	17 (65.4)
Current substance use	23 (16.3)	5 (19.2)
Current gambling	6 (4.3)	1 (3.8)
Any known familial alcohol use disorder	69 (48.9)	15 (57.7)

6.3.2   Self-reported psychological distress

Levels of self-reported depression and anxiety symptoms are presented in Table 5. The median overall HADS score (i.e. a combined measure of psychological distress out of a possible 42) was 23 (IQR = 11-32).

Table 5:   Self-reported depression and anxiety symptoms

Variable	Whole cohort n=141 n (%)	Qualitative sample n=26 n (%)
Depression symptoms (HADS subscale)		
Non-case (0 – 7)	58 (41.1)	10 (38.5)
Case (8 – 21)	83 (58.69)	16 (61.5)
Anxiety symptoms (HADS subscale)		
Non-case (0 – 7)	44 (31.2)	8 (30.8)
Case (8 – 21)	97 (68.8)	18 (69.2)

6.3.3   Context of hospital attendance/admission

Table 6 provides details of participants' hospital attendance/admission. Forty participants were discharged directly from the emergency department (ED); for the remainder who were admitted to hospital as inpatients (n=101, 71.6%), the median number of bed days was 7 (IQR = 4-19). For 103 participants (73%), their hospital attendance/admission was directly related to alcohol consumption (e.g. alcohol withdrawal, alcohol intoxication, alcohol-related gastritis), as per medical notes.

Almost half the cohort (42.6%, n=60) reported that emergency attendance or inpatient admission at T1 marked the first assessment of their alcohol use in a secondary-care setting. Most participants rated the assessment/discussion of their alcohol use as 'very positive' (n=73, 51.8%) or 'positive' (n=29, 20.6%), with only 7 (5.0%) rating it as 'negative' (the remainder selected 'neutral'). Participants who selected a 'negative' score most commonly reported doing so because they felt they needed inpatient detoxification but were discharged straight home from ED.

In terms of the nature of intervention offered by clinical staff, participants most commonly recalled receiving "advice" including that relating to alcohol-related harms, ways to reduce consumption, medical detoxification, or available relapse-prevention medication (n=122, 86.5%). Less than half the cohort reported receiving information about available community alcohol treatment services (n=58, 41.1%) and even fewer were directly referred (n=35, 24.8%). Of those with no prior alcohol treatment history (n=74, see Section 6.3.4 below), only 34 were signposted (45.9%) and 16 referred (21.6%). Ten participants (7.1%) were unable to recall the content of the discussion with staff.

Finally, many said they felt 'very confident' (n=57, 40.4%) or 'confident' (n=26, 18.4%) about making changes in their alcohol use following assessment in hospital, suggesting reasonable levels of self-efficacy (of note, 34.8% were 'ambivalent').

Table 6:   Details of participants' hospital attendance/admission

Variable	Whole cohort n=141 n (%)	Qualitative sample n=26 n (%)
Clear alcohol-related admission	103 (73.0)	22 (84.6)
ED attendance only	40 (28.4)	5 (19.2)
First assessment of alcohol use in hospital	60 (42.6)	7 (26.9)

6.3.4   Drinking profile

Table 7 provides a summary of the drinking profile of the cohort at T1 and includes information about use of alcohol treatment services.

Most participants reported consuming alcohol every day in the week prior to admission (median of 7 days, IQR = 4-7), with the majority consuming over 100 units across the week (median of 112.50 units, IQR = 52.5-189.5). Ninety-two participants (65.2%) scored 12/12 on the AUDIT-C,

and the majority scored ≥20 on the full AUDIT, indicative of probable dependence (median score of 32, IQR = 23-36). However, there was greater dispersion in self-reported psychological dependence as per LDQ scores (median score of 22.0, IQR = 9-28). Of note, 10 participants reported no alcohol consumption in the week prior to hospital attendance/admission; however, this group still had a mean AUDIT score of 23.5 (range 18-31). While there was variation in the type of alcohol consumed across the whole sample, individual participants reported a clear preference for one type of beverage.

Participants had relatively high levels of problem awareness and recognition of the need to access support for their drinking, evident in a high median 'problem perception' SOCRATES score (although note the wide IQR). Furthermore, a moderately high median 'taking action' score suggests that many participants reported a firm commitment to change, and/or were already taking steps to reduce their alcohol consumption. However, less than half the cohort (n=67, 47.5%) reported accessing specialist alcohol treatment at least once in the past, and only ~18% of the sample had utilised specialist alcohol treatment within the month prior to the current hospital attendance/admission.

Table 7:   Drinking profile and use of alcohol treatment services at baseline

Drinking profile	Whole cohort n=141 n (%)	Qualitative sample n=26 n (%)
Units consumed in the week before admission		
0	10 (7.1)	1 (3.8)
1 – 49	23 (16.3)	2 (7.7)
50 – 99	32 (22.7)	7 (26.9)
100 – 199	43 (30.5)	6 (23.1)
200+	33 (23.4)	10 (38.5)
Number of drinking days in the week before admission		
0	10 (7.1)	1 (3.8)
1 – 2	6 (4.3)	0 (0.0)
3 – 4	20 (14.2)	2 (7.7)
5 – 6	10 (7.1)	4 (15.4)
7	95 (67.4)	19 (73.1)
Number of heavy drinking days* in the week before admission		
0	17 (12.0)	1 (3.8)
1 – 2	10 (7.1)	1 (3.8)
3 – 4	18 (12.8)	3 (11.5)
5 – 6	11 (7.8)	4 (15.4)
7	85 (60.3)	17 (65.4)

Drinking profile	Whole cohort n=141 n (%)	Qualitative sample n=26 n (%)
Drink of choice		
Spirits	50 (35.5)	11 (42.3)
Normal strength cider or beer	31 (21.9)	5 (19.2)
Strong cider or beer	28 (19.9)	4 (15.4)
Wine	29 (20.6)	5 (19.2)
Other (e.g. liqueur)	3 (2.1)	1 (3.8)
AUDIT score		
0 – 7 (low risk)	0 (0.0)	0 (0.0)
8 – 15 (increasing risk)	4 (2.8)	0 (0.0)
16 – 19 (higher risk)	12 (8.5)	3 (11.5)
20+ (probable dependence)	125 (88.7)	23 (88.5)
LDQ score		
0 – 10 (low dependence)	41 (29.1)	4 (15.4)
11 – 30 (moderate-high dependence)	100 (70.9)	122 (84.6)
Readiness to change (possible score range)	**Median (IQR)**	**Median (IQR)**
SOCRATES subscales		
Problem Perception (10 – 50)	40 (32-45)	43 (39-46)
Taking Action (6 – 30)	23 (19-27)	25 (20-28)
Use of alcohol treatment services	**n (%)**	**n (%)**
Alcoholics Anonymous (AA)		
Last month	9 (6.4)	2 (7.7)
1-6 months	7 (5.0)	3 (11.5)
6-12 months	3 (2.1)	2 (7.7)
12+ months	28 (19.9)	6 (23.1)
Never	94 (66.7)	13 (50.0)
Community / Residential treatment service		
Last month	20 (14.2)	6 (23.1)
1-6 months	13 (9.2)	4 (15.4)
6-12 months	6 (4.2)	1 (3.8)
12+ months	28 (19.9)	4 (15.4)
Never	74 (52.5)	11 (42.3)
Healthcare (GP)		
Last month	31 (22.0)	5 (19.2)
1-6 months	7 (5.0)	1 (3.8)
6-12 months	7 (5.0)	3 (11.5)
12+ months	22 (15.6)	4 (15.4)
Never	74 (52.5)	13 (50.0)
No specialist alcohol treatment history**	74 (52.5)	10 (38.5)
In specialist alcohol treatment at baseline***	26 (18.4)	7 (26.9)

* Defined as >40g (5 units) per day for women and >60g (7.5 units) per day for men

** 'Alcohol treatment' defined as attendance at a community/residential alcohol treatment service or alcohol-specific mutual aid group (*** within the past month)

6.4 Participant trajectories in the six months following discharge from hospital (research question 3)

Apart from Section 6.4.1, which describes the deaths of 11 participants during the six-month follow-up period, the remaining analyses were based on observed cases (i.e. those who completed both baseline and follow-up interviews, n=121).

6.4.1 Deaths within the cohort

Table 8 provides a summary of the causes of, and context surrounding, the deaths of 11 participants during the 6-month follow-up period. All those who died were males aged between 36 and 74 years old. Liver disease was the direct cause of death for six participants, and a contributory factor in one participant. 'Alcohol Use Disorder' was mentioned as a contributory factor in an additional two participants. One individual (participant 1 in Table 8) died during the admission in which they were recruited to the study.

Eight participants were single and living alone, and eight were current smokers. Only one participant was currently working; seven were registered long term sick/disabled and three had retired. None of the participants were engaging in specialist alcohol treatment at the time of baseline interview; one had attended community treatment services four months prior to their hospital admission, six >12 months prior, and four reported no treatment history at all. Four participants reported that their alcohol use had never been assessed in a secondary care setting prior to their index admission.

A further eight participants (two females) died in the six months following the end of the study; this means 13.5% (n=19) of the cohort had died within 12 months of their baseline interview in hospital.

Table 8:   Summary of participant deaths

Pt	Age at death	Days between interview and death	Place of death	Cause(s) of death as per death certificate			Details of hospital use				
				Primary cause (1a)	Intermediate or underlying cause(s) (1b/1c)	Contributory causes (2)	Index admission bed days	Clear alcohol-related index admission?	First discussion of alcohol use in hospital?	Past 12-month hospital use	Specialist alcohol treatment?
1	36	38	Hospital	Hepatorenal syndrome	Decompensated alcohol-related liver cirrhosis	Vancomycin-resistant enterococci sepsis	44	Yes	No	1 ED attendance	>12 months
2	66	11	Home	Acute cardiac failure	Coronary artery atheroma	Hypertension; chronic misuse of alcohol	32	Yes	Yes	None	None
3	57	12	Hospital	Hyponatremia	Infective exacerbation of COPD	-	8	No	No	12 ED attendances	>12 months

Pt	Age at death	Days between interview and death	Place of death	Cause(s) of death as per death certificate			Details of hospital use				
				Primary cause (1a)	Intermediate or underlying cause(s) (1b/1c)	Contributory causes (2)	Index admission bed days	Clear alcohol-related index admission?	First discussion of alcohol use in hospital?	Past 12-month hospital use	Specialist alcohol treatment?
4	45	147	Hostel	Confluent Broncho-pneumonia	Tuberculosis	Tramadol and Pregabalin toxicity	13	No	Yes	None	>12 months
5	52	28	Hospital	Liver cirrhosis	Decompensated alcohol-related liver disease	Hepatocellular carcinoma	13	Yes	No	1 admission	>12 months
6	52	123	Home	Alcohol-related liver disease	-	-	7	No	No	3 admissions	1-6 months

				Cause(s) of death as per death certificate			Details of hospital use				
Pt	Age at death	Days between interview and death	Place of death	Primary cause (1a)	Intermediate or underlying cause(s) (1b/1c)	Contributory causes (2)	Index admission bed days	Clear alcohol-related index admission?	First discussion of alcohol use in hospital?	Past 12-month hospital use	Specialist alcohol treatment?
7	74	116	Hospital	Hepatorenal syndrome	Alcohol-related liver cirrhosis; hepatitis	-	6	Yes	Yes	1 admission & 1 ED attendance	None
8	62	90	"Wet" house	End stage liver failure	Hepatocellular carcinoma; Hepatitis C; alcohol-related liver disease	Adeno-carcinoma of rectum	0	Yes	No	9 admissions & 13 ED attendances	>12 months
9	66	128	Hospital	Sepsis	Urinary tract infection	Alcohol Use Disorder	25	Yes	Yes	None	None

Pt	Age at death	Days between interview and death	Place of death	Cause(s) of death as per death certificate			Details of hospital use				
				Primary cause (1a)	Intermediate or underlying cause(s) (1b/1c)	Contributory causes (2)	Index admission bed days	Clear alcohol-related index admission?	First discussion of alcohol use in hospital?	Past 12-month hospital use	Specialist alcohol treatment?
10	53	104	Hospice	Hepatocellular carcinoma	Alcohol-related liver disease	-	11	Yes	No	1 ED attendance	>12 months
11	65	62	Hospital	Community acquired pneumonia	COPD; lung cancer; tobacco smoking	Alcohol-related liver disease; frailty	0	Yes	No	1 admission & 1 ED attendance	None

6.4.2 Treatment engagement

Table 9 details participants' use of treatment/support services after hospital discharge. Forty-three percent of participants reported accessing some form of support for their alcohol use during the six months between baseline and follow-up (including non-specialist support such as online support, speaking to GP etc.). Just under 40% accessed specialist alcohol treatment at least once during the follow-up period (compared to 20.7% (25/121) engaging at baseline); 60.4% of these participants were still engaging at the 6-month point (this represents 24% of the whole cohort, n=121). Seventeen of the 48 individuals who accessed specialist treatment post-hospital discharge did so for the first time in their lives. Community alcohol services were the most frequently attended form of 'specialist treatment', followed by AA.

Table 9: Treatment engagement post-hospital discharge

Type of treatment/support accessed	Whole cohort n=121 n(%)	Qualitative sample n=26 n(%)
Any support during 6-month follow-up period	52 (43.0)	15 (57.7)
Specialist alcohol treatment at least once during 6-month follow-up period	48 (39.3)	14 (53.8)
Of those still engaging in specialist alcohol treatment at 6-months:	**Whole cohort n=48 n(%)**	**Qualitative sample n=14 n(%)**
Number who accessed specialist treatment for the first time ever	17 (35.4)	3 (21.4)
Number who were still engaging at the 6-month follow-up point	29 (60.4)	7 (50.0)

6.4.3 Changes in drinking behaviour and related variables

Table 10 displays the results of paired sample *t*-tests, comparing the cohort's mean score of variables measured at baseline and follow-up. For information, median scores are presented in Appendix O.

At six-month follow-up, 92 participants reported drinking less during the past week than at baseline, 19 increased their unit consumption, and 10 exhibited no change (5 continued to drink 7/7 days, and 5 maintained abstinence); there was a statistically significant mean reduction in

units consumed. Fifty-five participants (45.5%) reported no HDDs during the past week. Only 16 participants (13.2%) reported complete abstinence throughout the whole six-month follow-up period.

Participants exhibited significant reductions from baseline to follow-up in alcohol use disorder severity, psychological dependence on alcohol, and depression and anxiety symptoms. Participants' perception of alcohol as a problem significantly reduced between T1 and T2, but levels of action toward making changes did not. All significant changes, apart from change in anxiety symptoms, reflect medium to large effect sizes (Cohen, 1988).

Table 10:   Changes in participants' drinking behaviour and other related variables (T2 – T1) (n=121)

Variables (range)	Mean score at T1 (SD)	Mean score at T2 (SD)	Mean change (SD)	Mean change [95% CI]	p	Effect size (d)
Past-week unit consumption	139.67 (120.94)	63.78 (97.07)	-75.89 (131.38)	[-99.54, -52.24]	**<.001**	0.58
Past-week drinking days	5.64 (2.25)	3.34 (3.09)	-2.31 (3.26)	[-2.89, -1.72]	**<.001**	0.71
Past-week heavy drinking days	5.17 (2.59)	2.79 (3.10)	-2.38 (3.27)	[-2.97, -1.79]	**<.001**	0.73
AUD severity (AUDIT score, 0 – 40)	29.46 (7.40)	19.97 (11.51)	-9.50 (9.91)	[-11.28, -7.71]	**<.001**	0.96
Psychological dependence (LDQ score, 0 – 30)	18.45 (10.45)	10.93 (10.18)	-7.52 (10.05)	[-9.33, -5.71]	**<.001**	0.75
Problem Perception (SOCRATES score, 10 – 50)	37.74 (8.72)	31.41 (10.57)	-6.32 (9.11)	[-7.96, -4.68]	**<.001**	0.69
Taking Action (SOCRATES score, 6 – 30)	22.01 (6.71)	23.02 (6.99)	1.02 (8.93)	[-0.59, 2.62]	.213	0.11
Depression symptoms (HADS score 0 – 21)	9.72 (6.24)	6.73 (6.49)	-2.99 (6.02)	[-4.08, -5.47]	**<.001**	0.50
Anxiety symptoms (HADS score, 0 – 21)	11.74 (6.68)	9.79 (6.53)	-1.96 (6.03)	[-3.04, -0.87]	**.001**	0.33

6.4.4   Clinically significant and reliable change in psychological dependence

Reliable change

Table 11 displays the number of participants whose LDQ scores demonstrated each of the three reliable change outcomes (deterioration, no change, improvement). Sixty-five participants (53.7%) exhibited a reliable change in LDQ score from baseline to follow-up: 60 of these exhibited a reliable improvement in levels of psychological dependence, while 5 deteriorated. Of the 60 who reliably improved, 17 retained LDQ scores above 10.7, indicating continued high dependence but a move in the direction of improvement; eight stayed below the 10.7 threshold at both time points. Of those making no reliable change (n=56), 26 maintained low levels of dependence from baseline to follow-up (an LDQ score <10.7), meaning 30 maintained high levels of dependence.

Table 11:   Reliability of change in level of psychological dependence from baseline to follow-up as per LDQ scores

	Reliable deterioration	**No reliable change**	**Reliable improvement**
Whole cohort (n=121)	5 (4.1%)	56 (46.3%)	60 (49.6%)
Qualitative sample (n=26)	1 (3.8%)	7 (26.9%)	18 (69.2%)

Clinically significant change

At follow-up, 69/121 participants (57.0%) were below the threshold for clinically significant change, CSC (i.e. LDQ score <10.7). However, of these 69 individuals, 34 had baseline scores lower than the threshold, meaning it was not possible to make CSC; therefore, a total of 35/87 participants (40.2%) made clinically significant change in that they moved from levels of dependence more akin to a clinical sample, to dependence more akin to a 'well-functioning' sample (Raistrick *et al.*, 2014). All scores denoting clinically meaningful change *also* demonstrated reliable change. Thirteen participants in the qualitative sample (50.0%) made clinically significant (and reliable) change.

6.4.5 Change in heavy drinking days according to baseline characteristics

The results of independent samples *t*-tests comparing baseline groups in the change in heavy drinking days (T2 – T1) are presented in Table 12. For information, median scores are presented in Appendix P.

Significant differences were found according to participants' living situation, employment status, treatment engagement post-hospital discharge, level of psychological dependence, problem perception and depression symptoms. Specifically, those living with others, employed, who accessed specialist treatment post-hospital discharge, and had higher psychological dependence, problem perception and depression scores at baseline, reduced their number of heavy drinking days significantly more than their comparison groups. However, these differences may be explained by differences in baseline drinking levels (see 'Mean score at T1' in the table below), which are controlled for in regression analyses presented in Section 6.5 below.

Table 12:   Change in heavy drinking days (T2 - T1) according to baseline characteristics (n=121)

Variables	Mean HDDs at T1 (SD)	Mean HDDs at T2 (SD)	Mean change in HDDs (SD)	Mean difference [95% CI]	p	Effect size (d)
Socio-demographics (n/121)						
Gender						
Male (82)	5.02 (2.77)	2.70 (3.08)	-2.33 (3.50)	0.16	.805	0.05
Female (39)	5.49 (2.16)	3.00 (3.19)	-2.49 (2.68)	[-1.42, 0.88]		
Relationship status						
In a relationship (28)	5.82 (2.41)	2.93 (3.19)	-2.89 (3.29)	0.67	.347	0.20
Single (93)	4.98 (2.62)	2.75 (3.10)	-2.23 (3.27)	[-0.73, 2.07]		
Living situation						
Lives with others (52)	5.54 (2.45)	2.46 (3.13)	-3.08 (3.11)	1.22	**.040**	0.38
Living alone (69)	4.90 (2.67)	3.04 (3.08)	-1.86 (3.32)	[0.57, 2.39]		
Employment status						
Employed/in education (27)	6.11 (1.81)	2.59 (3.05)	-3.52 (2.93)	1.47	**.040**	0.47
Not in work (94)	4.90 (2.72)	2.85 (3.13)	-2.05 (2.93)	[0.70, 2.86]		
Smoking status						
Smoker (75)	5.28 (2.50)	3.11 (3.07)	-2.17 (3.22)	0.54	.377	0.17
Non-smoker (46)	5.00 (2.74)	2.28 (3.12)	-2.72 (3.36)	[-1.76, 0.67]		
Known familial alcohol use disorder						
Yes (62)	5.43 (2.45)	3.16 (3.19)	-2.23 (3.47)	0.32	.597	0.09
No (59)	4.96 (2.74)	2.41 (2.98)	-2.54 (3.08)	[-1.50, 0.87]		

Variables	Mean HDDs at T1 (SD)	Mean HDDs at T2 (SD)	Mean change in HDDs (SD)	Mean difference [95% CI]	p	Effect size (d)
Alcohol-related (n/121)						
Psychological dependence (LDQ score)						
Low dependence (0 – 10) (37)	3.24 (2.86)	2.19 (3.06)	-1.05 (2.85)	1.91	**.002**	0.62
Moderate-High dependence (11 – 21) (84)	6.02 (1.93)	3.06 (3.10)	-2.96 (3.30)	[0.74, 3.09]		
Problem perception (SOCRATES score)						
Low problem perception (10 – 40) (63)	4.30 (2.87)	2.75 (3.03)	-1.56 (3.07)	1.72	**.004**	0.54
High problem perception (41 – 50) (58)	6.12 (1.85)	2.84 (3.21)	-3.28 (3.28)	[0.57, 2.87]		
Taking action (SOCRATES score)						
Low taking action (6 – 23) (65)	5.38 (2.45)	3.06 (3.18)	-2.32 (2.80)	0.13	.841	0.04
High taking action (24 – 30) (56)	4.93 (2.74)	2.48 (3.01)	-2.45 (3.78)	[-1.09, 1.34]		
Baseline alcohol treatment engagement						
Yes, in treatment (25)	5.80 (2.18)	3.72 (3.14)	-2.08 (3.49)	0.38	.609	0.11
Not in treatment (96)	5.01 (2.67)	2.55 (3.06)	-2.46 (3.23)	[-1.84, 1.08]		
Post hospital alcohol treatment engagement						
Yes, in treatment (48)	5.73 (2.24)	2.44 (3.04)	-3.29 (3.27)	1.51	**.012**	0.47
Not in treatment (73)	4.81 (2.75)	3.03 (3.15)	-1.78 (3.16)	[0.33, 2.69]		
Hospital-related (n/121)						
Direct alcohol-related admission						
Yes (91)	5.34 (2.45)	2.79 (3.10)	-2.55 (3.37)	0.68	.324	0.21
No (30)	4.67 (2.96)	2.80 (3.18)	-1.87 (2.95)	[-0.68, 2.05]		

Variables	Mean HDDs at T1 (SD)	Mean HDDs at T2 (SD)	Mean change in HDDs (SD)	Mean difference [95% CI]	p	Effect size (d)
Context of hospital attendance						
Emergency department only (34)	5.29 (2.66)	2.97 (3.09)	-2.32 (3.31)	0.08	.906	0.02
Inpatient admission (87)	5.13 (2.57)	2.72 (3.12)	-2.40 (3.28)	[-1.40, 1.24]		
Assessment of alcohol use in secondary care setting						
First assessment (52)	4.98 (2.65)	2.46 (3.04)	-2.52 (3.10)	0.24	.687	0.07
History of previous assessments (69)	5.32 (2.55)	3.04 (3.12)	-2.28 (3.42)	[-0.95, 1.44]		
Psychological distress (n/121)						
Depression (HADS scores range)						
Low levels of depression (0 – 10) (50)	4.40 (2.96)	2.94 (3.13)	-1.46 (2.91)	1.57	**.007**	0.50
High depression (11 – 21) (71)	5.72 (2.15)	2.69 (3.10)	-3.03 (3.38)	[0.43, 2.71]		
Anxiety (HADS score range)						
Low levels of anxiety (0 – 10) (39)	4.67 (2.84)	3.03 (3.26)	-1.64 (3.02)	1.09	.077	0.34
High levels of anxiety (11 – 21) (82)	5.41 (2.44)	2.68 (3.04)	-2.73 (3.35)	[-0.12, 2.30]		

6.5 Predicting alcohol-related outcomes at six months (research question 4)

There were two outcomes of interest, operationalised as:

1. Primary analysis: alcohol consumption at six months (0 HDDs vs. ≥1 HDDs)
2. Secondary analysis: psychological dependence at six months (CSC in psychological dependence vs. no change/reliable deterioration)

Table 13 displays the proportion of participants demonstrating each outcome for the primary analysis (total n=121), and Table 14 displays the proportions for the secondary analysis (total n=87; 34 participants were excluded as they remained below the threshold – LDQ score of 10.7 – from baseline to follow-up, so making CSC was not possible). Although many participants displayed the same outcome (un/favourable) in both HDDs and psychological dependence, this was not always the case; 11.5% of participants with an unfavourable dependence outcome (n=52) reported 0 HDDs, and 22.9% of participants with a favourable dependence outcome (n=35) reported ≥1 HDDs (the Kappa coefficient of agreement value was 0.66). These discrepancies support qualitative narratives (Chapter 7) and justified a second regression analysis to explore potential predictors of change in dependence.

Table 13: Proportion of participants demonstrating favourable vs. unfavourable alcohol consumption outcome at six months

	Favourable outcome: 0 HDDs	Unfavourable outcome: ≥1 HDDs
Whole cohort (n=121, %)	55 (45.5)	66 (54.5)
Qualitative sample (n=26, %)	12 (46.2)	14 (53.8)

Table 14:   Proportion of participants demonstrating favourable vs. unfavourable psychological dependence outcome at six months

	Favourable outcome: Clinically significant and reliable change in dependence	Unfavourable outcome: No change in dependence or reliable deterioration	Excluded: Stayed below the threshold between T1-T2
Whole cohort (n=121, %)	35 (28.9)	52 (43.0)	34 (28.1)
Qualitative sample (n=26, %)	13 (50.0)	9 (34.6)	4 (15.4)

6.5.1   Separate 'minimally adjusted' models predicting alcohol-related outcomes at six months

Separate 'minimally adjusted' logistic regression models were fitted for each variable of interest to assess their association with favourable alcohol-related outcomes at six months. Participants' AUDIT score was not modelled as it is essentially an aggregate measure of drinking behaviour and symptoms of alcohol dependence, which were measured by other included variables; this is supported by the strong associations found in correlational analyses (Appendix R).

6.5.1.1   Predicting alcohol consumption at six months

'Minimally adjusted' models predicting favourable alcohol-consumption outcome are presented in Table 15. Variables found to be independently associated with a favourable drinking outcome at six months (in addition to baseline AUDIT-C score) were participants' living situation (those living with others were 2.3 times more likely to have a favourable outcome), smoking status (smokers were 2.9 times less likely to have a favourable outcome) and specialist alcohol treatment engagement at baseline (those in treatment were 3.3 times less likely to have a favourable outcome). Although failing to reach a level of significance, baseline substance use showed a trend for an unfavourable outcome.

Table 15: 'Minimally adjusted' logistic regression models of all variables predicting a favourable
outcome in alcohol consumption at six months (n=121)

Variables	B (SE)	AOR† [95% CI]	p	R²
Socio-demographics				
Age (for a 1-year difference)	.01 (.01)	1.00 [0.98, 1.03]	.748	.169
Male Gender	.29 (.43)	1.33 [0.58, 3.07]	.501	.172
In a relationship	.34 (.46)	1.40 [0.57, 3.47]	.466	.173
Living with others	.83 (.41)	2.29 [1.04, 5.07]	**.041**	.209
Employed/In Education	.01 (.47)	1.01 [0.40, 2.53]	.985	.168
Current smoker	-1.06 (.41)	0.35 [0.16, 0.77]	**.005**	.195
Current other substance use	-1.05 (.59)	0.35 [0.11, 1.13]	.078	.200
Familial alcohol use disorder	-.28 (.39)	0.76 [0.35, 1.63]	.475	.173
Alcohol-related				
Past 6-month average alcohol consumption (AUDIT-C score)	-.46 (.13)	0.63 [0.49, 0.82]	**.001**	.168
Psychological dependence (LDQ score)	-.01 (.02)	0.99 [0.95, 1.03]	.488	.172
Problem perception (subscale of SOCRATES)	.02 (.02)	1.02 [0.97, 1.07]	.433	.174
Taking Action (subscale of SOCRATES)	.02 (.03)	1.02 [0.96, 1.08]	.506	.172
In treatment at baseline	-1.20 (.58)	0.30 [0.10, 0.93]	**.036**	.215
In treatment following hospital discharge	.28 (.40)	1.32 [0.60, 2.89]	.492	.172
Self-efficacy	.21 (.19)	1.24 [0.85, 1.81]	.271	.179
Hospital-related				
Clear alcohol-related hospital attendance/admission	.11 (.46)	1.12 [0.46, 2.75]	.807	.168
ED attendance only	-.29 (.44)	0.75 [0.32, 1.79]	.520	.172

Variables	B (SE)	AOR† [95% CI]	p	R²
First assessment of alcohol use in secondary care setting	.45 (.40)	1.57 [0.72, 3.39]	.257	.180
Psychological distress				
Psychological distress (HADS score)	.00 (.02)	1.00 [.97, 1.04]	.830	.168

R^2 is reported as Nagelkerke's R^2.

†Adjusted for baseline AUDIT-C score

6.5.1.2   Predicting psychological dependence at six months

'Minimally adjusted' models predicting favourable psychological dependence outcome are presented in Table 16. Guided by personal communication with an author of the LDQ (Tober, 20/02/2018) and advice taken from a statistician at the University of Southampton, baseline LDQ score was not included as a covariate when modelling clinically significant change (CSC) in psychological dependence. This is because baseline LDQ score is used in the calculation of reliable and clinically significant change and is therefore structurally related to the outcome.

Demographic variables independently associated with CSC in psychological dependence were participants' living situation (those living with others had 3.1 greater odds of making CSC) and smoking status (non-smokers were 3.2 times as likely to make CSC). The only significant alcohol-related predictor was whether the individual was engaged in specialist alcohol treatment at baseline (those in treatment were >9 times more likely to demonstrate an unfavourable outcome). In terms of the hospital admission/attendance, those whose alcohol use was assessed for the first time in a secondary care setting were ~4 times more likely to have a favourable outcome at six months. Finally, increased self-efficacy showed a trend for a favourable outcome, as did being in a relationship.

Table 16: 'Minimally adjusted' logistic regression models of all variables predicting a favourable outcome in level of psychological dependence at six months (n=87)

Variables	B (SE)	AOR† [95% CI]	p	R^2
Socio-demographics				
Age (for a 1-year difference)	.013 (.02)	1.01 [0.98, 1.05]	.447	.045
Male Gender	.60 (.49)	1.83 [0.70, 4.79]	.221	.059
In a relationship	1.05 (.58)	2.89 [0.92, 8.87]	.071	.085
Living with others	1.14 (.46)	3.14 [1.26, 7.79]	**.014**	.127
Employed/In Education	.12 (.53)	1.13 [0.40, 3.20]	.824	.036
Current smoker	-1.17 (.48)	0.31 [0.12, 0.80]	**.015**	.125
Current other substance use	-.84 (.59)	0.43 [0.14, 1.37]	.125	.068
Familial alcohol use disorder	-.66 (.45)	0.52 [0.21, 1.26]	.147	.067
Drinking-related				
Past 6-month average alcohol consumption (AUDIT-C score)	-.22 (.15)	0.81 [0.61, 1.07]	.136	.036
Problem Perception (subscale of SOCRATES)	.02 (.04)	1.02 [0.95, 1.09]	.645	.039
Taking Action (subscale of SOCRATES)	.04 (.04)	1.04 [0.97, 1.11]	.271	.055
In treatment at baseline	-2.19 (.76)	0.11 [0.03, 0.50]	**.004**	.205
In treatment following hospital discharge	-.04 (.44)	0.96 [0.40, 2.29]	.924	.036
Self-efficacy	.43 (.22)	1.54 [0.99, 2.37]	.053	.096
Hospital-related				
Clear alcohol-related hospital attendance/admission	-.15 (.53)	0.86 [0.30, 2.45]	.780	.037
ED attendance only	-.51 (.51)	0.60 [0.22, 1.63]	.319	.051
First assessment of alcohol use in secondary care setting	1.44 (.48)	4.22 [1.63, 10.88]	**.003**	.170

Variables	B (SE)	AOR† [95% CI]	p	R^2
Psychological distress				
Psychological distress (HADS score)	-.02 (.02)	0.98 [0.94, 1.02]	.267	.054

R^2 is reported as Nagelkerke's R^2.

†Adjusted for baseline AUDIT-C score

6.5.2 Multivariable models predicting alcohol-related outcomes at six months

Variables identified as significant predictors in the separate 'minimally adjusted' regression models above (Section 6.5.1) were entered simultaneously into multiple regression analyses. The final models for both outcomes are presented below.

6.5.2.1 Final model predicting alcohol consumption at six months

The final model predicting alcohol consumption outcome is presented in Table 17. The 'initial model' (containing all independently associated variables) was significant, $X^2(4) = 21.87$, $p<.001$, and explained 30.9% of the variance in outcome at six months (correctly classifying 65.3% of cases). However, the Hosmer-Lemeshow test suggested poor model fit ($p=.052$). The model was fitted again, excluding participants' living situation ('final model' in Table 17), and remained significant, $X^2(3) = 29.35$, $p<.001$. The Hosmer-Lemeshow test then suggested adequate model fit ($p=.453$), and a partial likelihood ratio test further supported exclusion of the living situation variable ($X^2(3) = 4.85$, $p=$n.s.). The final model explained 28.8% of the variance in outcome at six months and correctly classified 72.7% of cases.

Table 17:   Final multiple logistic regression model predicting alcohol consumption at six months (n=121)

Model	Predictors	B (SE)	OR [95% CI]	p	R²
Initial model	Living with others	.66 (.43)	1.93 [0.84, 4.44]	.121	.309
	Current smoker	-1.11 (.43)	0.33 [0.14, 0.77]	**.010**	
	Specialist alcohol treatment engagement at baseline	-1.18 [.60]	0.31 [0.10, 0.99]	**.048**	
	AUDIT-C score at baseline	-.55 (.14)	0.58 [0.43, 0.76]	**<.001**	
Final model	Current smoker	-1.20 (.43)	0.30 [0.13, 0.70]	**.005**	.288
	Specialist alcohol treatment engagement at baseline	-1.23 [.59]	0.29 [0.09, 0.93]	**.037**	
	AUDIT-C score at baseline	-.54 (.14)	0.58 [0.44, 0.77]	**<.001**	

R^2 is reported as Nagelkerke's R^2.

6.5.2.2   Final model predicting psychological dependence at six months

The final model for dependence outcome is displayed in Table 18. The model was significant, $X^2(5)$ = 27.28, p<.001, and the Hosmer-Lemeshow test suggested acceptable model fit (p=.653). The model explained 36.4% of the variance in outcome at six months, and correctly classified 77.0% of cases.

Table 18:   Final multiple logistic regression model predicting clinically significant change in psychological dependence at six months (n=87)

Predictors	B (SE)	OR [95% CI]	p	R²
Living with others	.99 (.52)	2.69 [0.97, 7.46]	.058	.364
Current smoker	-.88 (.55)	0.41 [0.14, 1.23]	.111	
Specialist alcohol treatment engagement at baseline	-1.85 (.79)	0.16 [0.03, 0.73]	**.018**	
First assessment of alcohol use in hospital	1.02 (.54)	2.80 [0.97, 8.07]	.058	
AUDIT-C score at baseline	-.41 (.19)	0.66 [0.46, 0.96]	**.030**	

R^2 is reported as Nagelkerke's R^2.

6.6 Summary

6.6.1 The cohort's demographic and drinking profile

The first objectives of this chapter were to describe the personal characteristics and drinking profile of a cohort of patients with AUD presenting to one general hospital and begin to understand the role and acceptability of interventions for problematic alcohol use within this setting. My study identified patients who collectively reported high levels of alcohol consumption and dependence. This is not surprising as much of the sample were recruited via a specialist Alcohol Care Team (ACT) who mainly support individuals with moderate-severe AUD – and is in keeping with that reported in other studies of UK hospital-based addiction/alcohol teams, e.g. (Baker *et al.*, 2014; Ryder *et al.*, 2010; Watson *et al.*, 2015). Although many participants reported chronic, daily consumption, there was wide individual difference in drinking patterns, including several who identified themselves as "binge drinkers". There was considerable variation in self-reported psychological dependence on alcohol, as found in studies recruiting a similar population (Owens *et al.*, 2016; Watson *et al.*, 2015), with participants scoring the full possible range of LDQ scores.

Participants also described diverse drinking histories during interview and reported a range of treatment experiences. Importantly, >50% had never accessed specialist alcohol treatment, and only a small proportion were attending at the time of their hospital attendance/admission; this rate of non-treatment-seeking is common in general hospital patients with AUD (Bertholet *et al.*, 2010; Freyer *et al.*, 2007; Owens *et al.*, 2016; Parkman *et al.*, 2017b; Rumpf, Hapke and John, 1998). Of those with no prior treatment history, less than half reported being signposted to alcohol treatment services or mutual aid groups, and less than a quarter were directly referred; this finding is not new and suggests a missed opportunity to engage patients who may wish to access specialist treatment after discharge (Cucciare and Timko, 2015; Glass *et al.*, 2015; Lid *et al.*, 2012; Raven *et al.*, 2010), but reflects the current service provision model which prefers self- rather than professional referral. However, recent research has found that many hospital attendees with high levels of dependence do not want help with their alcohol use (Parkman *et al.*, 2017b), a finding I explored further in qualitative interviews (Chapters 8-9).

Participants' demographic profile also varied substantially, although trends within the cohort (e.g. the majority being male, single, living alone, and unemployed or registered long-term sick/disabled) concur with other hospital-based research of patients with severe AUD, e.g. (Bertholet *et al.*, 2010; Cobain *et al.*, 2011; Owens *et al.*, 2016). The context of participants' hospital visit also varied, with some attending ED only, and others requiring inpatient admission

for up to 85 days. While the majority were recorded as directly alcohol-related, around 30% were not.

Nearly half of the cohort reported that their admission/attendance at baseline marked the first discussion of their alcohol use in a hospital setting; while I could not verify whether this was actually the case, follow-up results (discussed below) and qualitative narratives (Chapter 8), highlight the potential significance of a first-time assessment. Furthermore, supporting other research (Broyles *et al.*, 2012; Groves *et al.*, 2010; McGeechan *et al.*, 2016), and corroborated by qualitative narratives (Chapter 8), participants were generally accepting of assessment and discussion of their alcohol use in hospital. However, it is possible that individuals who had a more positive assessment experience were more likely to agree to participate in a research study about their alcohol use (or were selected more often by clinical staff). Unfortunately, data were not available for the number of participants asked to participate by staff versus those recruited.

6.6.2 Participant trajectories

Collectively, participants made considerable change in their alcohol consumption during the six-month follow-up period with 80.2% reducing their unit intake or maintaining abstinence. All other variables also changed in the direction of improvement, apart from levels of 'problem perception', which significantly reduced. However, as problem perception is thought to be an indicator of alcohol problem severity (Bertholet *et al.*, 2009b), this may be considered a positive change rather than indication of increased 'denial'. Participants maintained similar levels of 'taking action' across the six months, although the number accessing alcohol treatment increased (note that the frequency and intensity of treatment was not assessed, and several participants reported attending services once after hospital discharge but decided not to return).

Change scores are helpful to assess the mean amount of change over time and are often reported in alcohol treatment/intervention studies examining statistical effectiveness, e.g. (Kaner *et al.*, 2007; McQueen *et al.*, 2011); the *t*-test results presented in Section 6.4.3 are compatible with this approach and can be used to inform sample size and power calculations for future research (including an indication of effect size for change over time). However, inferential statistics examining whether a group changed on average, ignores individual outcomes, and does not always translate to clinical or practical significance (Jacobson and Truax, 1991). Because of the qualitative impact of psychological dependence on wellbeing and quality of life (Chapter 7), participants' LDQ scores were assessed for clinically significant and reliable change (CSC). Almost half the cohort demonstrated reliable improvement, and of those with high dependence at baseline (i.e. those above the 10.7 LDQ score threshold, n=87), 40.2% demonstrated CSC in that

their scores moved reliably closer to the mean of a normative sample (Raistrick *et al.*, 2014). Given the significant association between LDQ scores and psychological distress (see Appendix R and (Fairhurst *et al.*, 2014), it is encouraging that a sizeable proportion of largely non-treatment-seeking participants demonstrated such change. Although Raistrick and colleagues (2014) reported a higher CSC rate of 51% where alcohol was the primary problem substance, their study recruited patients attending addiction treatment. Dependence is found to reduce early in treatment (Tober, 2000) and might therefore explain the difference in CSC rate found in my study.

It is important to acknowledge that some of the improvements observed might be due a 'regression to the mean' effect where reductions in high scores are seen with repeated measures. The potential impact of study participation can also not be ignored, as even assessment of alcohol use (without intervention) is often associated with change (Kypri *et al.*, 2007; McCambridge and Kypri, 2011), especially in general medical settings (Bischof *et al.*, 2012). Moreover, to retain statistical power, I considered the cohort a single group, although there may be differences in patients seen by different clinical teams (e.g. the pan-hospital specialist ACT vs. the ED-based VAST), with variations in the quality and length of interventions offered by staff. Indeed, a study exploring the role of 'alcohol health workers' across 48 different NHS hospitals in England, which included nursing and non-nursing staff, reported considerable diversity within and across hospitals (Baker *et al.*, 2014).

6.6.3 Predictors of change

While several baseline factors were found to be associated with greater reductions in HDDs (i.e. living with others, employment, specialist treatment access post-hospital discharge, and higher psychological dependence, problem perception and depression scores), this analysis failed to control for differences in drinking at baseline; participants with fewer baseline HDDs had less scope to change than individuals with greater HDDs. Thus, regression analyses were better suited to assess predictors of change, after controlling for differences in baseline consumption. A favourable drinking outcome, defined as zero HDDs, was informed by clinical experience and other studies which recognise that complete abstinence is not always a desired (or necessary) goal for many individuals (Gastfriend *et al.*, 2007; Mann, Aubin and Witkiewitz, 2017; Witkiewitz *et al.*, 2017), even those with severe physical ill-health (Lappalainen-Lehto *et al.*, 2013; Laramée *et al.*, 2015). Moreover, zero HDDs is accepted as a favourable outcome in clinical trials for the development of medications for treating AUD (European Medicines Agency, 2010; Food and Drug Administration, 2015), given the risk of HDDs for disease morbidity and mortality, negative consequences such as accidents and domestic violence, and increased costs to healthcare services (Aldridge *et al.*, 2016; Dawson, Li and Grant, 2008; Laramée *et al.*, 2015).

Logistic regression analyses identified four separate predictors of a favourable drinking outcome at six months: baseline consumption (AUDIT-C score), baseline alcohol treatment engagement, smoking status and living situation (although the latter was removed from the final multivariable model). In models predicting CSC in dependence, the same variables were identified as significant individual predictors, in addition to participants' assessment history of alcohol use in hospital, where first assessments were associated with greater odds of a favourable outcome. However, the significance of variables except baseline alcohol consumption and treatment engagement was attenuated in the final model. It is encouraging that few static risk factors (including age, gender, family history of AUD etc.) were associated with unfavourable outcomes at six months, as these are not amenable to change.

Baseline drinking was the strongest predictor of outcome in the model predicting heavy drinking and remained a significant predictor in the final model of dependence, which accords with research in treatment-seeking populations (Adamson, Sellman and Frampton, 2009; Peacock *et al.*, 2018). In a non-treatment seeking hospital-based sample, Bertholet et al. (2010) reported a non-significant association (OR 1.01, CI 0.98 – 1.04), but this might be explained by different measures of baseline drinking (average drinks per day in the past 30 days vs. past six-month consumption as per AUDIT-C score). Drinking behaviour in the weeks leading up to an unscheduled hospital attendance/admission might be atypical and therefore less predictive of longer-term outcomes. Other prospective cohort studies with general medical inpatients do not report an association between baseline and follow-up levels of drinking, e.g. (Freyer-Adam *et al.*, 2010; Rochat *et al.*, 2004; Williams *et al.*, 2010), so my results cannot be compared.

Baseline treatment engagement was a significant predictor in both final models and was associated with worse outcomes. Individuals in specialist alcohol treatment are consistently found to have more severe AUD, report greater adverse consequences from drinking, and have a history of prior help-seeking; they are also likely to have a range of other complex difficulties including comorbid substance use disorder, increased psychopathology, poor physical health, and suffer socioeconomic disadvantage (Rehm *et al.*, 2015; Rohn *et al.*, 2017; Storbjörk and Room, 2008; Tuithof *et al.*, 2016). Treatment utilisation is also found to be associated with features of social isolation, including having no partner (Tuithof *et al.*, 2016) and living alone (Freyer-Adam *et al.*, 2010), the latter of which was also a predictor of worse outcomes in my study[9]. As Chiappetta and colleagues (2014, p.142) note, although these factors increase the likelihood of attempts to

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[9] Inclusion of the variable 'treatment engagement at baseline' might therefore explain why participants' living situation became a non-significant predictor of outcomes in multivariable analyses.

address drinking, paradoxically, they also impede ability to succeed. It may therefore be these co-occurring problems, rather than treatment engagement per se, that increase the risk of consistently poor outcomes (Cunningham and McCambridge, 2011). However, continued engagement in specialist treatment might reinforce the perception of alcohol dependence as a chronic, severe disorder, which can reduce self-efficacy to change (Pienaar and Dilkes-Frayne, 2017; Pienaar *et al.*, 2015; 2016; Savic and Fomiatti, 2016); my qualitative analysis supports this assertion (Chapter 9). Moreover, time spent with heavy drinking peers is found to undermine efforts to change (Bertholet *et al.*, 2010; Weisner, Matzger and Kaskutas, 2003; Zywiak *et al.*, 2006). Disassociation and disidentification from others who have a problematic relationship with alcohol and advocate drinking, including those met during treatment, might therefore be necessary for sustained change (Bathish *et al.*, 2017; Stout *et al.*, 2012).

The relationship found between smoking status and outcomes is interesting. Several authors have documented the high prevalence of tobacco smoking in patients with AUD, which appears inflated within general hospital settings and as AUD severity increases (John *et al.*, 2003a; 2003b). For example, a recent study investigating the lifestyles of >3500 patients with AUD presenting to a general hospital found that patients with hazardous alcohol intake were two times as likely to be smokers compared to low-risk drinkers; those with alcohol dependence were more than seven times as likely to be smokers (Schwarz, Nielsen and Nielsen, 2018). In keeping with my findings, cigarette smoking is also found to be associated with poorer drinking outcomes, e.g. (Hufnagel *et al.*, 2017; Sarsour *et al.*, 2012), which suggests that efforts to address tobacco dependence in patients with AUD might be advantageous. However, concurrent treatment for both dependencies might not be helpful (Joseph *et al.*, 2004), and as the benefits of drinking cessation are typically experienced more rapidly, Schwarz et al. (2018) argue that this should take priority. Moreover, there is doubt whether smoking plays a causal role in drinking outcomes, or if its effect is due a shared aetiology with other variables such as psychiatric comorbidity and lower socioeconomic status (Le Strat, Ramoz and Gorwood, 2010; Taylor *et al.*, 2018).

Neither SOCRATES subscale scores were found to predict six-month outcomes in HDDs or levels of dependence[10], which is contrary to other research with a similar population. For example, Bertholet et al. (2010; 2009b) found that general medical inpatients with AUDs (78% alcohol dependent) who had 'taking action' scores in higher quartiles, reported less drinking at three and twelve months. Similar results of the effect of baseline motivation are presented in another

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[10] NB: The same pattern of results was found when using the 'Readiness to Change Questionnaire' (Rollnick *et al.*, 1992) instead of the SOCRATES in regression models (data not shown).

hospital-based study of non-dependent medical inpatients (Freyer-Adam *et al.*, 2010). However, for all these studies, participants were enrolled in randomised controlled trials (RCTs) in which they could receive alcohol counselling and may have therefore been predisposed to change. Although the RCT intervention was not associated with decreased drinking in each case (Freyer-Adam *et al.*, 2008; Saitz *et al.*, 2007), subgroup analysis of the RCT on which Bertholet and colleagues based their secondary analyses, found that individuals without alcohol dependence appeared to benefit from the intervention (Saitz *et al.*, 2009).

Factors related to my study design may have contributed to the null finding, including a lack of power to detect effects, and/or the dichotomisation of outcome, which is more limited than continuous measures of drinking and dependence. However, qualitative narratives triangulate the lack of association, that extend beyond the study design (Chapters 8 & 9). For example, some participants spoke of the difficulties in maintaining motivation upon return to an unsupportive home milieu. Others said that fluctuations in emotional wellbeing, cognitive functioning and physical health significantly affect their thoughts and behaviours relating to alcohol. Clearly further work is needed to explore the relationship between motivation and reductions in drinking in hospital populations, preferably outside the context of RCTs of brief interventions. However, my data suggest that the "chaotic nature of change" makes reliable prediction of outcome, according to motivation at one moment in time, difficult (West, 2006, p.179). Recent research shows that while motivation might increase *attempts* to reduce consumption, it may not translate to sustained change, at least in the general population (de Vocht *et al.*, 2018). It might be that self-efficacy (i.e. one's perceived capability to perform a behaviour) plays a greater role in effecting actual change (Bertholet *et al.*, 2012; Gaume, Bertholet and Daeppen, 2016; Williams *et al.*, 2007). Indeed, in minimally adjusted logistic regression analyses (Section 6.5 in Chapter 6), self-efficacy showed a stronger trend for favourable outcome than did motivation, particularly for levels of dependence (p=.053).

There was also no association between the reason for participants' hospital attendance/admission (i.e. coded as directly alcohol related or not) and outcomes. This is surprising given research which finds that "awareness of accumulating harms" and "triggering occurrences" can serve as catalysts for change (Orford *et al.*, 2006a). However, my qualitative analysis found that not all participants with an alcohol-attributable admission considered it to be so (Chapter 8), and personal attribution might be key to this process (Walton *et al.*, 2008; Williams *et al.*, 2010). Moreover, Williams and colleagues (2010), in their prospective cohort study of medical inpatients, found a decrease in HDDs among individuals with an alcohol-attributable hospital admission, but only for those who were non-dependent and/or had low problem

perception at baseline; participants in my study had higher levels of both dependence and problem perception which may also explain this lack of association.

A final finding worth considering is that those whose alcohol use was assessed for the first time in a hospital setting were four times more likely to make CSC in psychological dependence. While this association became non-significant in the final multivariable model (p=.058), it warrants further investigation. Individuals with a first-time assessment reported shorter and less severe drinking histories during qualitative interview (Chapter 8). They were also more likely to be treatment-naïve (86.7% vs. 27.7%, X^2 = 48.94, p<.001, ɸ = -.59) – making hospital attendance the first ever opportunity for some to talk about their use of alcohol – and less likely to access treatment post discharge (25% vs. 75%, X^2 = 10.05, p<.002, ɸ = -.29). Given that treatment-naïve individuals often choose to manage their consumption instead of committing to abstinence (LoCastro *et al.*, 2008; Sobell, Cunningham and Sobell, 1996), it is not surprising first-time assessments were associated with reductions in dependence, but not HDD outcome; limiting alcohol consumption to weekends for example, may still involve heavy drinking, but is likely to increase perception of control (i.e. reduced dependence). However, given the association between dependence and psychological distress found in correlation analysis (Appendix R), described in other research (Fairhurst *et al.*, 2014) and by participants during qualitative interview (Chapter 7), this is an encouraging finding, and points to the role of hospital attendance in shaping decisions about lifestyle choices. Clinical staff in hospital settings may wish to ask about history of prior alcohol assessments and optimise the experience of those who have never been assessed before.

6.6.4   Conclusions

The recruitment of a diverse cohort of patients is a key strength of this study as it reflects the heterogeneity of presentations seen in clinical practice (Blanco *et al.*, 2008; PHE, 2016) and facilitated rich qualitative exploration of a range of individual experiences (Chapters 7-9). Use of liberal inclusion criteria that invited participation from individuals with multiple and complex needs (e.g. alcohol dependence, psychiatric comorbidities, concurrent illicit substance use) undoubtedly supported this endeavour, as did widening recruitment to clinical teams beyond the ACT. While the representativeness of the cohort is limited by convenience sampling, and such broad inclusion criteria make direct comparisons with participants in other studies difficult, this was never the primary aim. The study also benefitted from high follow-up rates, helped by using 'locators' such as family and friends when participants were uncontactable, adopting a flexible approach to interviews, and offering financial remuneration; researchers of future studies may learn from such strategies to reduce attrition.

Few studies have examined the natural trajectory of drinking behaviour in patients with AUD presenting to hospital, and even fewer have assessed factors associated with outcome. Of the few cohort studies examining drinking outcomes in patients with AUD in general hospital settings, the majority are secondary analyses of data collected during RCTs. I identified only one UK-based study in which the authors conducted a prospective cohort control study in two acute hospitals, where one provided brief intervention of no predetermined number of sessions, and the other continued with routine care (Cobain *et al.*, 2011). However, their design did not allow for an examination of predictors of outcome, and as with all other studies, differences in the operationalisation of outcome variables make it difficult to compare my findings. My data therefore make an important and novel contribution to increasing understanding about the alcohol-related trajectories of patients seen within a general hospital setting. While many demonstrated significant change, some maintained high levels of alcohol consumption and dependence at six months. Together with the high death rate in the cohort, these findings support the need to explore further predictors of outcome and find ways to improve the services we deliver.

Chapter 7   QUALITATIVE RESULTS 1: DEVELOPING AN ALCOHOL-RELATED IDENTITY

7.1   Qualitative findings: Prelude

The results presented in the following three chapters (7-9) draw on data from in-depth qualitative interviews with 26 individuals who were followed-up at six months following their hospital attendance/admission. Analyses were grounded in the accounts of participants with a range of lived experience, though other sources of data were incorporated as the theory developed to contextualise narratives and increase the theoretical reach of findings.

The diversity of participant characteristics, use of alcohol over time, and treatment engagement, as highlighted in Chapter 6, mirrored the heterogeneity of qualitative narratives. It was common for participants with comparable quantitative outcomes to tell very different stories about their relationship with alcohol (and if applicable, their 'recovery'). Interviewing a range of people at different stages of change unveiled "multiplicity" both between and within participants' accounts (cf. Christensen and Elmeland, 2015). Those with more extensive drinking and/or treatment histories provided interesting insights into the evolution of alcohol problems over time (*"I've been around the block a few times",* Nathan; *"I have been there, read the book, got the t-shirt",* Trevor), which bared comparison to the narratives of participants who reported less persistent, or more recent, problems. The summary characteristics of participants interviewed were presented alongside those of the wider cohort in Chapter 6. A more detailed summary of participants' individual characteristics is presented in Appendix T.

My analysis supported the notion of recovery as a non-linear and evolving process, where evaluation of one's relationship with alcohol is subject to ongoing negotiation and re-negotiation (cf. Hartney *et al.*, 2003; Kougiali *et al.*, 2017). Importantly, all participants emphasised the individuality inherent in addiction and recovery:

> *"There will be themes, common themes, but the reasons behind [problematic alcohol use] are so complex and varied that each case is different."* (Clive)

A failure to find *"the magic recipe to say if you do this, do that, you will stop drinking"* (Steve) supports this assertion; accordingly, participants were tentative about suggesting definitive strategies to address a problematic relationship with alcohol because *"it's different for different people"* (Jack). With an acknowledgement that "recovery ultimately constitutes an individual

journey that could not be the same for any two people" (Neale *et al.*, 2015, p.31), the following three chapters highlight various determinants which shaped and defined this journey, as discussed by participants. Analysis focused on participants' own conceptualisations of their relationship with alcohol, and explored factors that contributed to this understanding, including attendance at an acute medical hospital.

For readability and ease of interpretation, the findings are presented linearly to explain:

- how and why an alcohol-related identity can develop (Chapter 7)
- the role hospital attendance/admission played in this process (Chapter 8)
- participant experiences of 'recovery' (Chapter 9)

Figure 8 depicts the theoretical framework, *'negotiating alcohol use and self'*, which highlights the interconnectivity between these three concepts, and illustrates the evolving nature of understanding and changing one's relationship with alcohol. The theory posits that conceptualisations of alcohol use and recovery are influenced by exposure to numerous, and at times conflicting, explanatory frameworks (detailed in the following three chapters); and these have important implications for the way we consider and treat individuals with AUD. The framework generated through interviews with members and browsers of *Soberistas* (Chapter 4) provided the springboard for exploring concepts relating to identity, labelling, and stigma, but new avenues were explored, as guided by participant narratives.

As reported in the wider literature, e.g. (Orford *et al.*, 2006a; Teruya and Hser, 2010), many "triggering events" or "turning points" were discussed as being of importance in participants' lives. However, the impact of hospital attendance/admission was considered in depth (Chapter 8) for three reasons:

- As all participants in the present study had an unscheduled hospital attendance/admission, their experiences could be compared and contrasted
- Ongoing analysis found hospital attendance/admission to be a unique event in participants' lives in the way it shaped conceptualisations of their drinking
- There is a scarcity of research, particularly qualitative in nature, examining the impact of hospital attendance/admission on drinking behaviour

Direct quotations[11] and illustrations from participants' PRISM diagrams (described in Section 5.2.7 of Chapter 5) demonstrate how the findings are grounded in the data. Quantitative results from

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[11] Pseudonyms are used to maintain participant anonymity.

Chapter 6 are discussed when relevant to qualitative narratives, as are findings from the literature, in keeping with grounded theory methodology (Chapter 3). Separate summary sections are included at the end of each chapter to discuss the implications of key findings within each concept; the final discussion chapter (Chapter 10) synthesises all findings, including those reported in previous studies within this thesis.
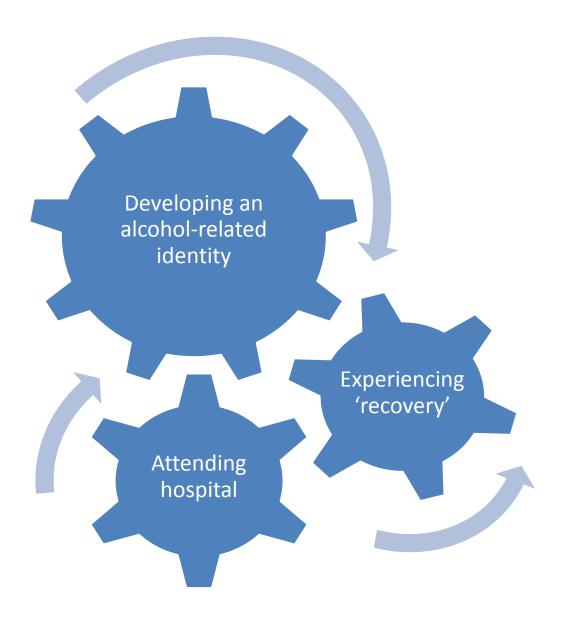
Figure 8:   "Negotiating alcohol use and self": a theoretical framework of the relationship between alcohol use, identity, hospital experience, and recovery

7.2   Chapter Introduction

This chapter includes results concerning the first concept (or 'cog' in Figure 8): *developing an alcohol-related identity*. The terminology used by participants to describe the impact alcohol had on their sense of self varied; a few self-identified as "alcoholics", others said they were "drinkers" or "drink dependent", while some rejected labels altogether. I therefore chose the term "alcohol-related identity" as it is broad and non-specific, and captures the experiences of all participants.

Two key factors were identified as playing a role in shaping the development of an identity defined by alcohol use. These are displayed in Figure 9 and discussed in turn, along with their corresponding categories:

1) **Nature and degree of alcohol dependence**
- "It just seemed like normality": low levels of dependence
- "Creeping up": unconscious dependence
- "Consuming me": the enmeshment of alcohol use and self
- "It's written all over my face": the embodiment of alcohol use

2) **Beliefs about the cause of problematic alcohol use**
- "It's in our DNA"
- Drinking as a disease
- Coping with psychological distress
- A choice

Figure 9:   Factors contributing to the development of an alcohol-related identity

7.3   Nature and degree of alcohol dependence

One of the most significant factors determining the impact of alcohol on identity was the nature and degree of participants' alcohol dependence. The following narrative elaborates on the relationship between dependence, alcohol use, and identity. Results are presented linearly from low to high dependence severity, mainly for simplicity; although when asked to provide a summary of their use of alcohol over time, most participants described a 'career' type progression of gradual escalation/severity. Nevertheless, further exploration of participants' journeys revealed significant fluctuation of alcohol use over time, including periods of *"controlled drinking"* and sometimes abstinence, in keeping with the process of change being discontinuous and non-linear (Kougiali *et al.*, 2017).

7.3.1   "It just seemed like normality": low levels of dependence

Participants' recollections of early experiences of drinking alcohol were characterised by enjoyment and sociability; a "normal" pattern of consumption, usually confined to weekends or evenings: *"I used to go out with my friends at weekends, drink, it wasn't an issue...it was normal; we wouldn't go out every night"* (Lorna). Time spent with others who drank in a similar way minimised the perception of alcohol as a problem, even though participants often reported consumption far more than recommended lower-risk levels:

> *"When I started playing darts and pool for the pubs and things…that was just like everybody else was drinking then, you know, 5 or 6 pints a night"* (Glen)

Generally, participants were nonchalant about this phase of drinking and reported few, if any, problems: *"Oh, it just seemed like normality. It wasn't something you thought of – it was just something you did in the evening. It never caused me problems then"* (Joe). This was reinforced through disc selection and placement on the PRISM diagram:

> *"It would be the small one because it wasn't really a big feature of my life. It was in there but not an important part really. So, I would say it was just on the edge of my life circle, not causing any problems."* (Barbara)

The main function of alcohol consumption at this stage appeared to be facilitation of sociability; drinking provided a gateway to positive social experiences, and it was this that participants identified with, rather than alcohol itself: *"alcohol wasn't a big thing…the pub was somewhere to meet your friends, you know?"* (Milo). Accordingly, descriptions of how alcohol influenced participants' self-concept tended to reflect alcohol acting as a 'social lubricant' and enhancing traits such as confidence and charisma. Lee, for example, said drinking alcohol magnified his *"happy-go-lucky"* personality, and Glen said it enabled him to perform his job as an onstage entertainer:

> *"I wasn't really worried about it [alcohol consumption]; it was just part and parcel of the job…I would never have been able to get up there and sing in front of people if I didn't have a drink first because of the nerves. It made me confident, absolutely."*

Participants rejected this pattern of drinking as evidence of dependence by making comparisons with friends or family who they believed were dependent (or "alcoholic"), and/or distinguishing between this "early phase" of drinking and their own later experiences. Hartney et al. (2003), in their grounded theory study of untreated heavy drinkers, also found this comparison process to be a key method by which individuals evaluate their own relationship with alcohol. However, as found in recent qualitative research with patients in primary care (Khadjesari *et al.*, 2018), using extreme examples of harm and dependence as benchmarks for problematic drinking increases the likelihood of individuals drinking at risky levels, to perceive their consumption as non-problematic.

7.3.2 "Creeping up": unconscious dependence

Following a period of "social drinking", many participants reported a "slippery slope" of increased consumption, which for some spanned many years: *"It was a gradual thing, I don't remember one day"* (Howard). This process was described as slow and largely unconscious; James explained that

"you don't notice it creeping up on you" – it is only with *"hindsight"*. Participants often alluded to their drinking as the formation of a habit and cementation of routine:

> *"I formulated a plan without even realising it, that if I went down to the supermarket and bought myself four litres of vodka…I could space it out and have enough vodka over the month. That was when I guess I was drinking every day without realising it."* (Daniel)

> *"It does just become a habit. I would sometimes wake up and before I'd go to work, it would be autopilot, have a little bit of drink to get me started."* (Lorna)

Many participants chose larger-sized discs in the PRISM task when describing this phase of drinking because of their recognition of increasing alcohol intake; not because of increased problems or personal suffering. Participants rarely placed the discs directly over the 'self' tile because of experiencing few negative consequences and an ongoing ability to function:

> *"I was going out, getting drunk, still maintaining my job; it didn't affect my job or anything like that, didn't affect work at all. It was just a way to let off steam."* (Simon)

Here, participants' disc placement is in keeping with findings of other research where higher Self-Illness Separation (SIS) on the PRISM task was associated with less intrusiveness and interference of the 'illness' with everyday life, e.g. (Büchi *et al.*, 2002; Reinhardt *et al.*, 2006).

Participant narratives provide support for the possibility of high levels of consumption alongside low levels of psychological dependence (Hartney *et al.*, 2003; Tober and Raistrick, 2004). However, many referred to this period of gradual escalation in alcohol use alongside low psychological dependence, as being the root of their problematic relationship with alcohol: *"that's probably, looking back, where the problems started"* (Lee). Consequently, those who had suffered adversities in relation to their drinking at the time of interview, often commented on the insidious nature of alcohol, describing it as *"cunning"* (Barbara), *"crude"* (Milo), *"patient"* (Len) and like a *"lurking tiger"* (Daniel). However, an ability to "keep a foot in the conventional world and assume socially valued identities by engaging in acceptable and productive activities" (Anderson and Levy, 2003, p.761), often quashed momentary concerns participants had about their use of alcohol – they simply organised their increasingly heavy consumption around other (more important) responsibilities and identities, such as roles at work, and within family/social life:

> *"I could get up and go to work every day, perform a normal life as such, although alcohol would play a part, but I was sort of functioning as a normal human being…you get up in the morning and go to work, I get up in the morning and have two or three drinks, [then] go to work."* (Nathan)

Participants appeared confident that their consumption, and efforts to conceal it, went largely undetected amongst colleagues and peers (*"no-one at work picked up on it at all…and the more you get away with it, the more you do it",* Rick), but also close family members:

> *"I found it harder to drink pints all night if I had had a big meal, a dinner, so I wouldn't eat a dinner. Or I would make myself ill after eating so I could fit alcohol in…and that became normal. And even though we had been living in the same house, and all the holidays, she [partner] still didn't pick up that I'd go to the toilet after every meal to make myself ill, so I was able to drink."* (Lee)

Research with individuals who use other substances also found that many effectively sustained both 'user' and 'non-drug user' identities for long periods of time (Gibson, Acquah and Robinson, 2004). Several participants in the present study even described a sense of accomplishment in successfully *"juggling"* these various identities, which often reinforced their drinking behaviour. The examples from Lorna and Joe below illustrate this particularly well:

> *"I know it sounds silly and a bit weird, it's not like I am bragging, but I think I did it right; like throughout the day I really paced myself with it…It was like I knew when my peaks were, so I never let it get to withdrawal…I timed it perfectly. Even my therapist said, "you're too smart – you are actually doing it too well, you're not stupid". I wish I was stupid, maybe I would have felt worse sooner. I knew my body so well and I played to it, 100%...and then it was the buzz of getting away with it."* (Lorna)

> *"Lying about how much you're drinking, or making excuses, or asking someone to do something so you can get them out the way to drink…Every time I was deceitful there was a feeling of guilt but there's also, when you pull off a maneuverer if you were, there's a greater feeling of success. If you manipulate people to do something and you get what you want at the end of it then…'hurrah'."* (Joe)

Although there were occasions where participants were "caught out" by family, partners and/or colleagues, many simply told people *"what they wanted to hear"* (Lee) and *"just kept going"* (Joe). In Joe's case, he was caught drinking at work, but as *"nothing really material happened",* he continued to drink as before. Examples of the deliberate use of a range of strategies to enable regular and/or heavy alcohol consumption *"without getting caught"* (Nathan), suggests that

contrary to the 'denial' stereotype, participants often perceived their consumption as unhealthy or "wrong" long before taking steps to address it; Graham said, *"deep down you're aware of it, but having another drink is easier than having to think about it"*. It was at this point that participants recalled first questioning whether their drinking "habit" had crossed the boundaries to 'qualify' as dependence. However, as Rick described earlier, *"getting away with it"* generated confidence and reduced pertinence to change. The lack of reported treatment access at this stage corroborates other work which finds that levels of psychological dependence and alcohol-related psychosocial problems are stronger predictors of help-seeking than heavy consumption, e.g. (Lloyd *et al.*, 2004; LoCastro *et al.*, 2008; Orford *et al.*, 2006b; Storbjörk and Room, 2008).

Participants' experiences of maintaining a "normal" life alongside heavy alcohol use echo the stories told by *Soberistas* members and browsers (Section 4.5 in Chapter 4). However, there appeared to be more variation within participants here in the degree to which they experienced, and then managed, cognitive dissonance; as Joe explained above, the sense of achievement in *"manipulat[ing] people to…get what you want"* outweighed the feelings of guilt, which contributed to his ongoing alcohol use. Generally, *Soberistas* participants described quite high levels of dissonance between their drinking and valued personal/social identities and took steps to gain control over their alcohol use to alleviate this (see Section 4.6 in Chapter 4). Some participants in the present study did struggle with *"living a double life"* (Lee) and found some relief in getting support to stop drinking, whether planned (e.g. voluntarily engaging with treatment services), or not (e.g. attending hospital). Other research has found that felt obligation to fulfil important roles that conflict with substance use often prompts change before significant adverse consequences of use, materialise (Chambers *et al.*, 2017; Granfield and Cloud, 2001). However, for those able to tolerate the *"juggling act"* (Nathan), consumption typically continued.

7.3.3   "Consuming me": the enmeshment of alcohol use and self

Several participants reported a further stage of increasing alcohol intake and/or dependence severity which was associated with more stress, and less success, in managing the demands of everyday life. As alcohol took up greater space in the individual's life, the repercussions of heavy drinking and psychological dependence were more apparent: many described significant life-changing events such as the loss of relationships, jobs, and homes. Correspondingly, the SIS on the PRISM became smaller, with participants now placing the alcohol discs closer to themselves:

> *"I went on the booze in 2012. I was trying to work as well, but I was heavy drinking...all I was concentrating on was getting through work to go back and have a drink. So, I guess it would be the big circle but only half over me because I was managing work and stuff."*
> (Luke)

Generally, the discs encroached further on the 'self' tile as participants reported more time being spent obtaining, consuming, and recovering from the effects of alcohol. Many said they began to prioritise alcohol above other responsibilities, such as employment. This pre-occupation and growing salience of alcohol at the expense of other important routines/activities are key indicators of dependence (Raistrick *et al.*, 1994; World Health Organisation, 2017). Luke, continuing from above, said:

> *"I eventually decided to give up the job because all I wanted was the drink...it was consuming me...once my money ran out, I was constantly thinking how I was going to get another drink."*

Others sacrificed relationships with friends and family members:

> *"I've been a very selfish man. I have neglected them [his children] by not spending time with them...my whole life revolves around alcohol and that's pretty sad but that's being honest."*
> (Jack)

The PRISM diagram was a helpful tool for participants to illustrate the impact alcohol had on their lives: for example, Daniel, in describing how *"ridiculous"* his drinking became said, *"you need bigger circles"* and drew additional 'extra-large' circles by hand (see Figure 10). In addition to more tangible consequences like those described above, changes to mentality reinforced the perception that alcohol had "taken over". Graham said, *"as soon as the word 'drink' came into my mind I thought, have you got enough? It was automatic".* Similarly, Nathan said he became a *"mathematician"*:

> *"I would be sitting in the [supermarket] queue and my brain would go, 'which one of those will I get the best hit from?' Vodka, 30 odd percent...boom, boom, boom...I'd be like a mathematician; which was going to last the longest? Which is going to give me that feeling fastest? It's all that, you're like a mathematician, continually counting in your head."*

These accounts depict automaticity in thinking which accords with research highlighting the role of impulsive cognitive processes in ongoing consumption and relapse (Baumeister, Heatherton and Tice, 1994; Wiers *et al.*, 2013).

INTERVIEW 12
#15.

(7) XXXL DISC – Taking over life. "Lost weeks at a time" Gave up work. Just drink – sleep – Hospital – detox – repeat.

My Life

My Self

SMALL DISC – Childhood ①

Small Disc – Adolescence, social drinking ②

(6) "You need bigger circles"
★ Lost marriage
★ Still working
★ 500 + days of stupidity from alcohol

MEDIUM DISC – ↑ consumption. Take it or leave it. ③

(5) LARGE DISC – drinking at work. Alcohol more important than relationship

MEDIUM – "creeping closer" Some negative consequences. ④

Figure 10:   Scanned copy of Daniel's PRISM diagram

For participants who had experienced many of the symptoms of dependence (Raistrick *et al.*, 1994), the boundary between 'self' and alcohol became increasingly blurred, to the point where some were unable to separate the two: *"it becomes part of who you are"* (Len). Here, alcohol consumption as a *behaviour* merged with how participants defined themselves: *"It takes over you as a person, and it becomes the person"* (Milo). The narrative of alcohol consumption as the 'dominant framework of self' (Corte, 2007; Corte and Stein, 2007; Denzin, 1993; Lindgren *et al.*, 2017) was almost exclusively found within descriptions of more severe stages of dependence. Importantly, in keeping with Raistrick and colleague's (1994) conceptualisation of dependence as a psychological state, participants did not necessarily have to experience physical symptoms to report severe dependence. Furthermore, those who did experience physical symptoms were not necessarily severely dependent – although as Raistrick et al. (1994) note, and interview data confirm, withdrawal often contributes to strengthening dependence. Trevor's account highlights this phenomenon well:

> **Interviewer: Can you tell me what it's like to have a dependence on it [alcohol]?**
>
> *Trevor: Well it don't particularly bother me.*
>
> **Interviewer: It doesn't bother you?**
>
> *Trevor: Erm, there is something bad about it. If you get up one day and you haven't got the pennies to get what you need. If you haven't got the money, you think, what can I sell? Who will buy it? Just for a stupid £4 bottle of juice to stop the shakes, rattles, and rolls. Once I've got that juice in me, I feel normal, I feel like me again."*

Here, Trevor suggests that his dependence on alcohol was only an inconvenience when his routine of steady consumption was disrupted, and he experienced symptoms of withdrawal (see Section 7.3.4 below for further discussion on the effects of withdrawal on self and the embodiment of alcohol use). Supporting this, Shilling (2008, p.12) argues that routines, even those considered unhealthy, maintain a sense of equilibrium and are vital in helping individuals manage their surroundings and operate effectively. Nettleton et al. (2011) reported similar results in their work with heroin users; so long as heroin was readily available, participants described stability between their internal and external worlds. These findings support the notion that persistent behaviours tend to be functional for people, even though they might not conform to societal norms of 'functionality' (Kelly and Barker, 2016).

Accordingly, it is possible to understand how even those with severe *physical* dependence on alcohol could report being psychologically *"comfortable in [their] own little darkened madness"* (Lee). The quantitative findings support this claim: measures of alcohol consumption (heavy drinking days and alcohol unit intake) demonstrated weaker associations with depression and anxiety symptoms, than did levels of psychological dependence as per LDQ score (Appendix R). This suggests that one's *relationship* with alcohol is more closely linked to levels of psychological distress than the quantity or frequency of use.

Further analysis of Trevor's account above highlights that the routines and embodied experiences associated with dependent drinking were a source of information from which he negotiated his identity: *"Once I've got that juice in me, I feel normal, I feel like me again".* He continued:

> *"I am addicted to the routine of it. Alcohol makes me, me. How should I put this? Over the last god knows how many years, there hasn't been a single day that I haven't bought a bottle of sauce [alcohol]. Now that's my problem, I know…but it's part of me, it's part of my daily life now…I get up and have a glass of cider because that's what I do. I don't think about it, I just do it. But I obviously do that because I am an 'alcoholic'."*

For Trevor, the routines and practices that went with being "an alcoholic" were just as salient as alcohol itself. Several other accounts resonated with this: Marie, for example, described her drinking as a *"regime",* and Daniel said, *"I could wake up in the morning and think I need to brush my teeth, get dressed, and I have got to get some beer today. It becomes a part of your agenda."* Many also discussed the association between their routine of drinking, and addiction to cigarette smoking (17/26 participants were current smokers): *"it's a drink in one hand, and a smoke in the other"* (Marie); *"for me drinking and smoking go together"* (Robert). This triangulates my quantitative findings (Chapter 6), and other research that alcohol problems are often related to a clustering of other lifestyle factors, including smoking (Schwarz, Nielsen and Nielsen, 2018).

Participants often reported high levels of distress when they failed to develop 'functional' routines of consumption, or when they perceived a complete inability to manage the impact alcohol had on their lives (this is in keeping with the quantitative associations found between psychological dependence and depressive/anxiety symptoms described earlier). Both scenarios resulted in psychological instability and feelings of powerlessness: Barbara said she felt as though she was *"drowning"* and Daniel explained, *"It dragged me to a place I had never been before, like a riptide...it's a wart on your life, a cancer".* Referring to the PRISM diagram, Howard said:

> *"The 'alcoholic' in me becomes that big red circle towering over me, and I feel like a little boy being crushed by it."*

Howard's reference to the 'alcoholic' in him resonates with a common finding within the literature that perceived differences in personhood during periods of intoxication versus periods of abstinence can result in a divided sense of self, e.g. (Mackintosh and Knight, 2012; Punzi and Tidefors, 2014; Shinebourne and Smith, 2009). Howard continued to say, *"It's like...Jekyll and Hyde"*, an analogy used by several other participants to describe the feeling that *"there were two people inside of [them]"* (Milo). Supporting this, Barbara, drinking at the time of interview, said:

> *"I am not normally like this but now I am. I seem to have lost all...I don't care about myself whereas I used to go and have a facial once a week and have my nails done every fortnight, have my hair done every month. But now I just, what's the point? When I'm not drinking, I wouldn't be sat here in these rags."* (Barbara)

While some participants affirmed that their 'real' self was the alcohol-free version, those with particularly extensive drinking histories were unsure: *"Well to be honest I don't know which one is the real one because I don't know what it's like to be Jekyll [i.e. alcohol-free] for any great length of time"* (Trevor). This depicts an extreme form of alcohol-self enmeshment.

Reflection on the ways in which alcohol altered the individual and their behaviour revealed a common narrative of shame. However, participants explained that instead of being a deterrent, feelings of shame often perpetuated their drinking, a finding reported elsewhere (Sawer, 2016; Wiechelt, 2007). Howard's example highlights this:

> *"I just don't want to be in that place where I am laid on the sofa leaning over a saucepan throwing up; and then you miss, and the carpet is horrible, and then you feel uncomfortable and full of shame because it's a really nice flat and the furniture is lovely, and everything is right, but then the carpet is dirty…and then I don't want to see it, so I get drunk again."*

While drinking alcohol temporarily relieved feelings of shame, it also reinforced them by providing self-confirmatory evidence of their identity as an 'alcoholic' – an identity that often carries negative connotations (Hill and Leeming, 2014; Khadjesari *et al.*, 2015; Schomerus *et al.*, 2011a; Wallhed-Finn, Bakshi and Andréasson, 2014). Graham, for example, said he became *"what people generally term an alcoholic…just useless, erm, wouldn't do, couldn't do anything…drinking at 10 o'clock in the morning. There's a bit of a stigma attached to alcohol I think; maybe rightfully so."*

Graham's excerpt suggests that 'alcoholism' and associated behaviours, such as morning drinking, give rise to stigma. However, analysis of further interview data suggested that some participants understood the relationship between alcohol dependence and stigma to be cyclical; stigma itself was described as a precursor to further drinking:

> *"You actually realise you're believing what people think of you, yourself, which then puts you in a position where you lose your own self-respect, which in turn makes you think 'stuff it' – if that's what they think of me, then I am going to carry on drinking and drink more."*
> (James)

Here, negative evaluations of alcohol use extended to James' overall perception of self, resulting in diminished *"self-respect"*. In another illustration of this effect, Marie conflated the *"disgusting things]she] did"* when intoxicated, with being a *"disgusting"* person:

> *"What it [alcohol] makes me do is disgusting, yeh, it affects my behaviour [pause] I think drink just makes you disgusting really, to be honest with you. And I don't like to be disgusting."* (Marie).

Thus, when alcohol was internalised as an unfavourable totalising identity, participants appeared to suffer more global low self-worth. Corrigan and colleagues (2016), in their study of self-stigma and mental illness, report similar results; those who internalised negative stereotypes of mental illness were more likely to suffer self-disrespect, and subsequent abandonment of personal goals

– which the authors term the "why try" effect. These findings are supported by research which proposes that individuals with a 'simple' self-concept (i.e. one characterised by a limited number of self-aspects, with more overlap between the attributes that describe each aspect) are more susceptible to emotional distress because negative information transfers more readily to other facets of self (Linville, 1985;1987). This fits with participants' narratives that increased dependence severity is usually associated with fewer self-domains unrelated to alcohol use; previously unrelated identities were either sacrificed because of increasing dependence (e.g. through relationship breakdown, loss of employment etc.), or became enmeshed with alcohol (e.g. friendships glued together by drinking: *"drinkers stick together",* Jack).

7.3.4 "It's written all over my face": the embodiment of alcohol use

Several participants said they relied on the way their body felt or looked to provide information about their relationship with alcohol. The embodied experience of alcohol use appeared to strengthen the fusion of drinking with 'self', and echoes Gibson et al.'s (2004) notion of an "entangled identity" where one's body becomes symbolic of one's substance use. Experience of physical withdrawal symptoms marked a particularly salient shift in perceptions of self, where several participants stated that they only started to consider their identity as an 'alcoholic' at this point:

> *"The shaking stuff only happened about 2 years ago. That's when I started thinking, hang on mate, am I an alcoholic? I didn't crave a drink, but it [drinking alcohol] was the only thing that really calmed me down and stopped me shaking."* (Glen)

The synonymy between being an 'alcoholic' and displaying signs of physical dependence (by experiencing withdrawal symptoms) was repeated in several interviews. This association appeared to have a profound impact in that participants became acutely aware of how they were perceived by others (*"to me, that's [shaking/sweating] a real give away, it's written all over my face that I am an alcoholic",* Daniel) – but also because it affected their ability to perform everyday tasks:

> *"It was embarrassing; I was constantly shaking all the time…it was getting to the stage where when I paid for things, I would only use a note because I could give them the note, but if I had change, it would go all over the place – you might think you have composed yourself and then they ask for another 10p or something, and oh…it was horrendous. Little things like that, erm…writing my mum's birthday card and trying to write but I couldn't do it."* (Graham)

While Graham said, *"it's funny in hindsight",* that he was teased for having handwriting like an *"oscilloscope",* the effects of withdrawal were clearly very distressing at the time, acting as a constant reminder of his reliance on alcohol. Similarly, other participants spoke of how alcohol dependence restricted their freedom to make plans and travel because of the unpredictability of episodes of withdrawal and sickness:

> *"I was gagging; I had all this foam, sticky horrible stuff and it used to make me gag, and I couldn't go on buses because I never knew when it was going to happen and once I started retching that was it, I'd be sick. I put all that down to alcohol, definitely…it was totally affecting my life because I couldn't go on a bus; I had to take my rucksack with me and a bag and I was gagging and being sick. I done that twice and I said I ain't going to town anymore."* (Glen)

Whereas in earlier stages of dependence where alcohol was considered just "one factor in a self-sustaining lifestyle" (Hartney *et al.*, 2003, p.327), severe physical dependence demanded the individual's full attention and contributed to an "entangled identity" (Gibson, Acquah and Robinson, 2004). Furthermore, attempts to avoid signs and symptoms of withdrawal often became a primary motivation for ongoing consumption, and served to reinforce the entrenched 'routinisation' of heavy drinking:

> *"I would wake up with fear which I didn't understand at the time, you know. But really, I became petrified of not getting enough alcohol and fitting."* (Milo)

> *"You get in the withdrawal-drink-vomit-repeat cycle."* (Trevor)

Like Milo, several other participants expressed fear of withdrawal, heightened by awareness of the potentially fatal consequences. Contrasts were occasionally drawn between alcohol and drugs in this respect:

> *"Alcohol is the most dangerous drug, it's ridiculously dangerous…you can get like a hardcore heroin addict, chuck him in a room, say, "shut the fuck up, I will see you in a week", and he would be fine; get an alcoholic, chuck him in a room and the chances are he would be dead within a few days."* (Daniel)

Participants with histories of severe physical dependence discussed the pain involved in efforts to consume alcohol and *"make sure it stayed down"* (Donna). Nathan's account is particularly poignant:

"You look at the bottle, have a big swig of it, and it hits you, and you think, 'oh god'. You go to the bathroom and you're retching and throwing up. And you run back to have another swig, and back to the bathroom retching. And so then you'd just take the bottle into the bathroom with you. You'd take 3 or 4 swigs before it stays down. And you're still there fighting with it to stay. You know it has to stay there otherwise you're going to be in trouble; it has to stay in your body to get that sensation to stop the shakes and all that. But your body is rejecting alcohol because you're too ill. And you're throwing it back up again and you just keep taking more until it stays down. And when it stays down you're set up for the day. I've had about 5 glasses of brandy in the morning and the 5 glasses came back up again. Literally came back up. And the horrible taste, the acid in your stomach, it's, urgh, it's become infected, your stomach is just acid; your whole insides, you're bring up…I hate talking about this, makes me feel 'urgh'…"

Evident in Nathan's narrative is the tension between mind and body. He described considerable determination to override his body's rejection of alcohol else he would *"be in trouble"*. Nathan's account, and Milo's above, highlight that the cognitive-emotional *response* to withdrawal played a key role in maintaining their drinking, reinforced through prior experience that further alcohol intake suppressed withdrawal symptoms (Raistrick *et al.*, 1994).

The cycle of drinking alcohol to relieve physical withdrawal (or fear of physical withdrawal) often resulted in diminished self-efficacy to build a life free from alcohol; Jack said, *"I just accepted it at the end of the day because I knew there was nothing I could do about it"*. Narratives of *"accepted inevitability"* (Daniel) were markedly different from accounts of earlier stages of dependence in terms of emotional detachment and despondence – several participants said they had just "given up" or "stopped caring". Moreover, for a few participants, a complete 'loss of self' accompanied their experience of chronic physical dependence and persistent withdrawal – several described an 'inner emptiness' (Denzin, 1993; Klingemann, 1992). Instead of having "fewer" self-domains, as discussed in the previous section, these participants described having *no* self-domains: *"I don't think of myself as anything or anybody with alcohol; alcohol sucks me of me"* (Barbara); *"I was a nobody"* (Lee). Nathan even described himself as *"dead"*:

"I just died. I used to find myself more and more empty. When you met me in the hospital, that was the end of the line there – there was just nothing there anymore…I was a dead person, a piece of meat in the bed."

These extracts highlight the impact of physical dependence and withdrawal on identity; at this level of severity, participants' identities appeared to be defined solely in terms of their corporeal dependence on alcohol – Nathan felt he was nothing but a *"piece of meat"*.

Further investigation of the impact of physical dependence and withdrawal from alcohol is needed as there is currently no published qualitative investigation with which to compare the present findings. One study (n=6), published in 2005, examined participants' fears of undertaking medically-assisted alcohol detoxification, and found the physical consequences and pain of withdrawal to be a primary concern (Allen, Copello and Orford, 2005). However, the fears of those experiencing withdrawal alone are likely to be quite different from those supported within a supervised treatment facility. Furthermore, it seems the relentless *"day in, day out"* (Graham) experiences of physical dependence and withdrawal are particularly impactful on quality of life and are important in shaping definitions of self. A single qualitative study exploring patients' experiences of Benzodiazepine cessation (symptoms of which are not dissimilar to abrupt alcohol cessation) also found that "withdrawal is difficult, complicated, and unpredictable" (Liebrenz *et al.*, 2015, p.122).

7.4 Beliefs about the cause of problematic drinking

Analysis of interview data highlighted that in addition to experience of dependence, the factors participants attributed as the cause of their (problematic) drinking, also influenced their conceptualisations of self. Importantly, the aim of this section of analysis is not to provide a comprehensive overview of theories of addiction; such a review can be found elsewhere, e.g. (West, 2006). Rather, only the factors that were described by participants and found to have 'analytic weight' (Chapter 3), are discussed.

7.4.1 "It's in our DNA"

Several participants understood their problematic drinking as the product of inheritance, and listed family members who also had difficulties with alcohol. When asked if addiction is something someone is born with, Daniel, for example, said:

> *"Yeh. I have never looked at alcohol as a disease, I don't agree with that. But what I did look at was that I had become my dad and my uncle, an 'alcoholic'. My auntie died last year, just from alcohol. My cousin died a few days ago, pretty much from alcohol."*

Some individuals reported no familial addiction but discussed having an "addictive personality", or traits that increased the probability of using substances; Jack for example, said he was *"born a rebel".* Many described experience of addiction to other substances, particularly smoking. Others discussed the association between genetic predisposition and growing up in family environments that placed emphasis on heavy alcohol use:

"My mum used to be an 'alcoholic', and my dad, he's an 'alcoholic'. That's all I knew back from when I was a kid, like I saw them drinking a lot. I was never taught to enjoy a drink like normal people do, it was always used as a way to cope – things get hard, you hit the bottle."
(Lily)

A few participants described a cumulative effect where presence of genetic and/or environmental factors culminated in greater risk of developing alcohol problems:

"Every one of us, we all ended up in homes, taken off our parents; that was the only release we had, you know, getting off your face drinking…But oh, alcoholism is hereditary. It's hereditary, and then if you've got the additional addictiveness, that compulsion, addictive personality thing going as well, you have got both elements to contain." (Nathan)

Participants who cited genetic causes of their problematic drinking tended to use the term 'alcoholic' as an essentialising noun in that it explained who they were as a person (Brekhus, 2003); Milo said that being an 'alcoholic' is woven into the most basic fabric of life – *"it's in our DNA".* As reported elsewhere, e.g. (Meurk *et al.*, 2016), many found this a helpful framework for conceptualising their relationship with alcohol because *"it helped [them] to understand what's wrong with [them]"* (Luke), and was considered to reduce shame as it is *"not the person's fault…it's not a personal choice or failing"* (Milo). However, some expressed concern about using genetic predisposition as an *excuse* for drinking and related (unfavourable) behaviour, which can fuel stigmatisation against individuals with addictions (Meurk *et al.*, 2013; Schomerus *et al.*, 2011a; Schomerus, Matschinger and Angermeyer, 2014). Moreover, a few individuals alluded to this understanding of problematic drinking as serving a 'self-fulfilling function': *"it's part of who we are, there is always a chance we will slip"* (Milo). This perspective may have implications for individuals' self-efficacy to remain alcohol-free.

Participants also expressed mixed emotions about the implications for future generations if problematic drinking is indeed heritable. Younger participants often felt empowered to change the course of their life before it was too late (*"I know alcohol stuff runs in families, but I don't want to turn out like my parents",* Lily), which resonates with Hanninen and Koski-Jannes' (1999) "co-dependence story" in their narrative analysis of recovery from various addictions; here, individuals perceived themselves as "the victim of a curse that extends over generations" (p.1844), and awareness of "the curse" enabled them to change their own future. However, in the present study, and others, e.g. (Hammer *et al.*, 2012) some participants expressed concern if "the curse" could not be broken:

> *"I looked back at my family, mum and dad aren't ['alcoholic'], although two of my uncles*
> *were heavy drinkers and have both had problems through drink, and smoking, and now they*
> *have died, recently. So ok, maybe it is in the family, but not immediate family. And then I got*
> *concerned that my daughters aren't…oh no please don't say my granddaughter is, please*
> *don't say this bad thing that has happened to me is going to happen to that lovely little girl*
> *that dotes on me. And that was dangerous because I punished myself."* (Lee)

For Lee, instead of alleviating guilt, contemplating his problematic drinking as being heritable provoked anxiety about the potential harm for his granddaughter, and 'increased awareness' of "the curse" did little to remedy that. Hence, framing addiction as an incurable and irreversible genetic disorder might not always mitigate feelings of shame or reduce stigma (Phelan, 2005; Young, 2011b); nevertheless, for several participants in the present study, it provided a rational *explanation* of their drinking behaviour and identity as an 'alcoholic'.

7.4.2   Drinking as a disease

Many participants described their problematic relationship with alcohol as the symptom of a "disease" or "illness". Again, the term 'alcoholic' was typically used, here signifying that the individual was 'unwell', and accords with the 12-step philosophy. In fact, several participants who endorsed this conceptualisation of problematic drinking were committed AA members, such as Len:

> *"I would say it's an illness, and so would AA. I do believe that I was ill, and I believe that if*
> *you have a craving, you're ill. I'll be an 'alcoholic' for the rest of my life…once you're an*
> *'alcoholic', you're always an 'alcoholic', whether you're a wet 'alcoholic' or a dry 'alcoholic',*
> *just happens to depend. I could have gone another 30 years without drink, but I would have*
> *still died an 'alcoholic'."*

Some participants felt this view of alcohol problems was met with more sympathy and less stigma, and could increase treatment utilisation (these purported benefits of the 'disease model of addiction' echo those commonly discussed in the literature, e.g. (Dingel *et al.,* 2017; Lebowitz and Appelbaum, 2017; Leshner, 1997; Schomerus, Matschinger and Angermeyer, 2014):

> *"You don't feel you deserve help if it is self-inflicted but maybe if we were to all change the*
> *way we thought about chronic, serious drinking, it would be better seen as an illness, so*
> *people can get more help. Having it as an actual illness or a disease means you're not going*
> *crazy, there might actually be a medical reason, a genuine reason why I am like this."*
> (Barbara)

Even participants who did not believe diseased-based explanations for their drinking recognised the potential 'uses' of such conceptualisations, including the enablement of continued consumption during periods of heavy drinking:

> *"By me saying, 'I am an alcoholic, I need help' …I don't know how to word this, but I got 4 cans of beer twice a day out of it, because I had to have alcohol. So, my wife had to give me 4 cans in the morning and 4 cans at night because I might possibly have a fit. Brilliant. You know my brain was like, what else can I do to get more? I'll admit to anything – yes I've got PTSD, yes I'm an 'alcoholic' – just give me alcohol."* (Lee)

In a similar vein, Trevor said he adopted the 'alcoholic' label as he felt it supported his application for welfare benefits, but favoured the term "Alcohol Use Disorder" because it *"sounds a bit more official":*

> *"That sounds wonderful, that is better. Can you put that on my medical certificate? To get your PIP, personal independence payment, you have to have something wrong with you."*

Although Lee and Trevor recognised the momentary benefits of affirming one's identity as an 'alcoholic', other participants discussed longer-term disadvantages. For example, some participants were concerned about the disease model's requirement to surrender volition; some felt that being permanently marked as "diseased" with little control to change its course, evoked a stigmatised personal identity (Goffman, 1963) and other work supports this finding, e.g. (Fraser *et al.*, 2017; Hammer *et al.*, 2013; Hammer *et al.*, 2012; Heather, 2017; Meurk *et al.*, 2016; Pienaar and Dilkes-Frayne, 2017; Wiens and Walker, 2015). Young (2011) notes that the disease model "firmly fixes the boundary between normal drinker and alcoholic; once drinkers assume the alcoholic label, they cannot easily resume the normal drinker identity" (p.385). James' excerpt below speaks to this:

> *"The worst thing I have ever turned around and said to anybody is that I am an 'alcoholic'. I should never have ever said it. And that's what I'm stuck with now…and it's down to that simple stigma. If I hadn't have said that I don't think I would have had half my troubles…I think the first thing they have to do is get rid of that horrible label, 'alcoholic'. You walk around with it with the fact that whoever looks at you, you think that they know you're an 'alcoholic', even when you're as sober as a judge."*

Thus, the irreversibility described by Young (2011) was a key reason some participants rejected the 'alcoholic' label, although in doing so, several feared accusations of being 'in denial': *"no-one can say they're not an 'alcoholic', because as soon as you say you're not, you are"* (Daniel). Although, when one considers the potential personal and social ramifications of embodying the

stigmatised 'alcoholic' label (Goffman, 1963; Schomerus *et al.*, 2011b; Schomerus *et al.*, 2011a), denial or 'deflection' is a logical, defensive response against a threat to one's identity (Thoits, 2016; Young, 2011b). However, data, including my own (see Chapter 6), support the notion that individuals with heavy alcohol consumption/dependence often have high levels of problem awareness, e.g. (Bertholet *et al.*, 2009b; Collins, Logan and Neighbors, 2010; Simpson and Tucker, 2002; Small *et al.*, 2012), which implies it is the 'alcoholic' identity that is being rejected, not that drinking is a problem. This is different from Thoits' (2016) concept of "identity deflection" which describes conscious rejection of the notion that one even *has* a mental disorder to protect oneself from discrimination and devaluation by others.

One solution provided by participants to overcome their concerns of having a permanent disease (even during periods of abstinence) was to conceptualise their drinking as an illness that *"comes and goes"* (Clive). Here, the 'alcoholic' label was used with some fluidity to describe episodes of heavy consumption (e.g. *"my drinking has fluctuated, how much I drink and how often…I changed from being 'alcoholic' in 1992 to not being 'alcoholic' in 1993",* Marie), and fits with narratives of alcohol being used to self-medicate during periods of distress (see Section 7.4.3 below). Several others agreed that what one *does* determines who one *is*:

> *"The way I see it, an 'alcoholic' will drink anything; they will drink the strongest, cheapest cider…you have heard of them drinking hand gel."* (Glen)

> *"I know what an 'alcoholic' is because my mum used to be one, you know what I mean? She would get up every morning, have a litre, small bottle, anything under her pillow, get up straight away, the first thing she would go for is the drink."* (Lily)

From this perspective, one's identity as an 'alcoholic' changes alongside behaviour, which concurs with Hughes' (2007) analysis that "practices of addiction" shape and define 'addict' identities. However, the ability to "de-label" (Howard, 2006) was strongly contested by a few participants who argued that being an 'alcoholic' is a life-long, totalising identity, and attempts to dilute it reflect an individual's lack of acceptance of who they are. Len provided an interesting metaphor: *"you can't be half pregnant; you're pregnant or you're not pregnant"* – however, one can imagine Marie, who said was an 'alcoholic' in 1992 but not in 1993, might argue that one is no longer pregnant after giving birth!

These qualitative narratives prompted an exploratory post-hoc analysis to assess whether participants' responses to two SOCRATES items, which pertain to drinking identity (*"I am a problem drinker"* and *"I am an alcoholic"*), demonstrated any change between baseline and follow-up. A Wilcoxon signed-rank test determined that there was a statistically significant

median difference in scores for both SOCRATES items which triangulates qualitative narratives of alcohol-related self-concept fluidity (see Table 19). However, 42/121 individuals retained the same score at both time points for the item relating to "problem drinker" identity, and 71/121 individuals for the item relating to "alcoholic" identity; this suggests that for some individuals (such as Len, mentioned above), there was consistency over the six month follow-up period in how they defined themselves according to their relationship with alcohol, even alongside changes in alcohol consumption.

Table 19:   Differences in SOCRATES scores between baseline and 6-month follow-up, for items pertaining to drinking identity (n=121)

	Median (IQR) score at baseline (range 1-5*)	Median (IQR) score at 6-month follow-up (range 1-5*)	Statistical test (z)	p
"I am a problem drinker"	3 (2 – 5)	2 (1 – 4)	3.20	.001
"I am an alcoholic"	5 (2 – 5)	3 (1 – 5)	3.28	.001

*Where: 1 = "strongly disagree", 3 = "unsure", 5 = "strongly agree"

7.4.3   Coping with psychological distress

Several participants stated their problematic drinking was *"inextricably caught up with depression…a direct result of, a consequence of, mental illness"* (Clive). Instead of viewing their dependence on alcohol as evidence of disease or genetic predisposition, some participants described the *deliberate* use of alcohol to cope with periods of distress:

> *"When you are in such a bad place and you feel like drinking is the only way out, that's the only way you can cope with things…I'd say the drinking itself isn't an illness; alcohol is like your medicine to cope with other mental illnesses."* (Lily)

Descriptions such as that provided by Lily accord with the 'Self-medication Model' of addiction which proposes that individuals intentionally use substances to alleviate the suffering associated with emotional stress or mental illness (Khantzian, 1985;1997). Consequently, participants felt the

onus was not to address their problematic relationship with alcohol, but rather to understand and relieve their broader experience of distress:

> *"I don't know if I had a problem because as I said, I was using it as a medicine. I suppose from the outside looking in people would say it's a problem, but for me, it was a tool to cope with what I had been through. And as I improved, mentally accepted the situation more, my drinking naturally petered off…it was losing my wife that was the problem, not the alcohol."* (Simon)

Hammer et al. (2012) describe this interpretation of 'addiction' as a "punctured equilibrium…a problem that oscillates along a static equilibrium, flaring only with specific triggers" (p.718). Thus, while some participants did consider themselves *"drink-dependent"* or *"addicted"* at certain points in their life, many rejected a permanent 'alcoholic' identity, for example:

> *"I knew I wasn't [alcoholic] because I didn't have to drink every day…at that time, I wanted to use it [alcohol] to get through that difficult time."* (Glen)

When asked to indicate on the PRISM diagram where alcohol fitted in his life during this period, Glen selected the large 'alcohol disc' and placed it directly over himself. According to the authors of PRISM, such a placement indicates high levels of suffering (Büchi *et al.*, 2002), and prior to Glen's interview, participant narratives alongside their use of the PRISM generally corroborated this interpretation. However, when asked to explain his choice of disc and placement, Glen said:

> *"Well the reason why I said that is because it [alcohol] had taken over me, but I wanted it to take over me, because it helped me. It wasn't the drink that I loved, it is what it done for me, it made me sleep, made me calm down, and I wasn't thinking about things which were mental; the drink helped my mental things."*

Here, placement of the 'alcohol disc' over oneself represented a welcomed escape from unpleasant affective states and life circumstances – not suffering.

In addition to using alcohol to escape from adversities, a few participants described drinking to escape from *themselves*. Donna, for example, said: *"alcohol sort of takes me away from who I am…it puts the brakes on who I am".* Similarly, Clive explained that he used alcohol not to change who he was as a person, but to escape him:

> *"Clive: Alcohol does make time go away, it does make the day go away, and it means you don't have to face yourself…you want to withdraw from yourself.*
>
> ***Interviewer: Can you explain what you mean by withdraw from yourself?***

> *Clive: To get rid of yourself, get away from yourself, to get away from your own thoughts. Not be a different person, but to not be anybody…and drink is one of those things that does that."*

Unlike participants who described an "enmeshment" of identity where alcohol *became* the 'self' (see Section 7.3.3), narratives such as those of Donna and Clive above suggest that alcohol was used strategically for the person to get *away from* their 'self'. This form of escape was typically described in the context of poor mental health; participants most commonly reported a history of bipolar disorder, anxiety, depression, or post-traumatic stress disorder (PTSD); all these diagnoses can involve disruptions to the individual's sense of self, e.g. through internalisation of highly negative self-evaluations or failing to develop a robust sense of self leading to feelings of emptiness and numbness (Stopa, 2009).

In these cases, participants usually considered their heavy drinking to be 'acceptable' as it served an 'appropriate' function of coping with trauma or mental illness (a finding also reported by (Hartney *et al.*, 2003). By way of affirming this acceptability, some contrasted their "type of drinking" with what they understood 'alcoholic' drinking to be. Lynn, for example said:

> *"I didn't think I was an 'alcoholic' because I had a very obvious trigger for drinking…an 'alcoholic' drinks regardless, even if there's nothing wrong."*

By creating distance between their "type of drinking" and that of an 'alcoholic', participants were able to avoid the negative stereotypes associated with the label (Chambers *et al.*, 2017; Hill and Leeming, 2014; Khadjesari *et al.*, 2015; Robinson, 2016), and supports research which finds that alcohol dependence is met with more social stigma than other mental disorders (Schomerus *et al.*, 2011a). Corroborating this, participants in the present study appeared much more willing to discuss with others their experience of poor mental health than problems with alcohol:

> *"There is a social stigma and a significant lack of understanding of drug and alcohol problems. Work have already shown an awareness of my mental illness and depression and they have been very, very good about that, so I see no reason to take it any further; why create a problem [and tell them about his drinking]?"* (Clive)

Clive explained that he felt mental illness is met with greater sympathy because it is not *"self-inflicted"* in the way that alcohol dependence is perceived to be. Moreover, for some participants, rejection of the 'alcoholic' label reflected their belief that it reduced their complex myriad of symptoms and experiences, to a stigmatising total identity:

>*"The anxiety is the core problem; alcohol came as a result of trying to cope with that. Saying I'm an 'alcoholic' is just completely forbidding, ignoring everything else I have been through. The anxiety was actually the root, the alcohol was just my medication."* (Lorna)

Therefore, by emphasising their psychological distress instead of 'alcoholism' as the core problem, participants hoped others would be more accepting of their use of alcohol to cope. Moreover, several individuals said they believed anyone in their situation would behave in the same way and described *"how easy it can happen; how easy it is to drink"* (Donna). This supports other qualitative work which found that individuals sometimes frame their addiction using "normalising discourses" whereby their behaviour exists along a continuum of 'normal' human experience (Hammer *et al.*, 2012; Meurk *et al.*, 2016).

7.4.4 A choice

The notion of 'free-will' within the context of addiction is contested, e.g. (Fenton and Wiers, 2017; Heyman, 2017; Karasaki *et al.*, 2013; Reith, 2004). However, many participants reported considerable personal control over their alcohol consumption, supporting a "rational informed stable choice model of behaviour" (West, 2006, p.29). Even participants with experience of severe alcohol dependence reported moments of *"lucidness…a bit of sanity"* (Rick), and several agreed with Barbara who said, *"you're the one tipping it down your throat".* Furthermore, even individuals who subscribed to the disease model of addiction, like Len, (Section 7.4.2) attested to having choice:

>*"I would say it's an illness, and so would AA…it's not an excuse for drinking, there is no excuse for drinking. You have a choice; you either drink or you don't."*

The choice to drink was often driven by perceived benefits such as relaxation and enjoyment (*"I just enjoy the taste and just relaxing, having a drink"*, Simon); and so long as *"no-one suffers because of it"* (Robert), participants generally considered these as "acceptable" reasons to drink, supporting findings reported in other research (Hartney *et al.*, 2003). The social/cultural normativity of alcohol consumption for pleasure (Bartram, Eliott and Crabb, 2017), appeared to reinforce this:

>*"I have got to be honest, I enjoy a gin and tonic, I enjoy a glass of wine, and that's very normal, nothing wrong with that"* (Gillian).

Participants who had experienced severe physical dependence and suffered alcohol-related harm also reported drinking because of the pleasurable benefits, for example:

"I just do my business, go to the shop, come home, lock myself away and say 'hallelujah' [laughs]. I like drinking. I like the taste of it, that's what it is." (Trevor)

"I need a drink in the morning to get me up and running, but my drinking is definitely sort of, like, a high percentage is just pleasure or thrill-seeking." (Daniel)

Importantly, these excerpts were interspersed among narratives of addiction articulated as a "disorder of compulsion", defined by loss of control and personal agency (Pienaar *et al.*, 2016). Daniel (quoted above), for example, had also stated: *"alcohol is the one thing in my life that I have got absolutely no control over"*. Several authors have suggested that therapeutic encounters and social/political conceptualisations of addiction require individuals to reify their experience as one of uncontrollable compulsion that needs treatment, e.g. (Barnett *et al.*, 2018; Fomiatti, Moore and Fraser, 2017; Klingemann, 2011; Pienaar *et al.*, 2015; 2016; Reinarman, 2005; Savic *et al.*, 2016; 2017; Savic and Fomiatti, 2016). Internalisation of this dominant discourse alongside personal examples of control over drinking, may explain the presence of both volition and compulsion narratives within the same interviews.

For some participants, discussion of ongoing consumption within the context of a hospital-based alcohol research interview – where the harms of drinking were recent and salient – appeared to elicit feelings of 'stupidity' (e.g. *"talking about it makes me realise how stupid it all is. It sounds ridiculous when you say it out-loud",* Trevor). Others said their behaviour was evidence of *"complete insanity"* (Nathan). However, examples of individuals choosing to drink because of the perceived benefits (e.g. for pleasure, or to cope with psychological distress and adversity, as outlined in 7.4.4), not only infers personal agency, but also suggests logical decision making.

These findings corroborate recent work which has examined the potential benefits of heavy alcohol consumption. For example, Moore et al. (2017), in their qualitative study of people who describe themselves as having an 'addiction', 'dependence' or drug 'habit', found that heavy alcohol and other drug use can be conducive for health and wellbeing in that it helped some individuals cope with physical and emotional pain, corroborating the narratives presented in 7.4.3. Moreover, in a separate analysis of the same interview data (collected as part of the Australian 'Social Studies of Addiction Concepts' research programme), Pienaar and Dilkes-Frayne (2017) present stories of individuals who felt their drug use afforded benefits that did not involve coping with adversity, such as improving their concentration at work. They concluded that people can "thrive with the kind of consumption that would attract a diagnosis of addiction or dependence" (p. 150), and suggest it is naïve to assume that suffering and trauma are *necessarily* woven into the experience of addiction. Even when behaviours, such as heavy alcohol consumption, do carry risks, Kelly and Barker (2016) argue "it is important not to dismiss the

explanations people give of what they do" (p.7) because they are often serving an important function. They continue:

> "It is extremely arrogant to assume that people consume alcohol…because they are irrational or are simply behaving thoughtlessly or stupidly. Human actors are profoundly knowledgeable about their own behaviour, they can account for it in meaningful ways which not only make sense to them, but if we take the trouble to hear those accounts, the rationality within them is clear." (p.6-7)

7.5   Summary

This chapter outlined factors that were identified in participant narratives as playing a key role in shaping the development of an alcohol-related identity. Specifically, my analysis suggest that level of dependence was more significant in participants' conceptualisation of their relationship with alcohol – and had greater impact on wellbeing, functioning, and identity – than level of consumption. Indeed, placement of the alcohol disc over oneself during the PRISM task, usually considered indicative of suffering / greater impact on self (Büchi *et al.*, 1998), occurred more often in the context of describing experience of dependence than increased levels of consumption. This finding supports the disaggregation of dependence from consumption (Heather, 2013; Tober and Raistrick, 2004) and justifies the secondary regression analysis to predict dependence at six months (Chapter 6).

Measures of consumption, while usually correlated with dependence (see Appendix R for associations found in the cohort study), provide no indication about the psychological processes underpinning alcohol use (Tober, 2000); and it is these processes that were found to have the most impact on participants' functioning and sense of self. For example, intolerable compulsion to continue drinking despite adverse consequences, total preoccupation with alcohol, and disruption to one's everyday routine, were all experiences described as having a significant (usually negative) impact on daily life. These are all markers of dependence as measured by the Leeds Dependence Questionnaire (Raistrick *et al.,* 1994), which was used in quantitative analyses (Chapter 6). Participant narratives therefore provide support for Raistrick et al.'s (1994) conceptualisation of dependence as a psychological state; even those who described physical symptoms of dependence (e.g. withdrawal) emphasised the cognitive-behavioural and emotional (i.e. psychological) components of this experience.

However, my data also speak to the social-perceptual view of dependence (Hartney, 2004; Hartney *et al.*, 2003); this model considers the role of comparisons with other drinkers and conformity to socially accepted drinking norms in evaluations of one's level of dependence.

Supporting this view, recent research shows that when individuals perceive themselves to be fundamentally different from the stereotype of "problem drinker", they often evaluate their drinking as non-problematic, despite consuming alcohol at risky levels (Khadjesari *et al.,* 2018). Almost all participants in my study described a time when they deemed their drinking to be unproblematic, despite consuming vast quantities of alcohol (e.g. Section 7.3.1). This may be because they had created distance between themselves and "problem drinkers" in line with Hartney et al.'s (2003) findings, and/or they experienced a high degree of control over their drinking at that time, i.e. low levels of dependence as defined by (Raistrick *et al.,* 1994). Either way, perception and experience of dependence appeared more important for participants' wellbeing, functioning and identity, than the units they consumed; this might explain why alcohol unit guidance is often considered irrelevant by individuals who drink (Khadjesari *et al.*, 2018; Lovatt *et al.*, 2015).

The other key factor identified as influencing conceptualisations of alcohol use on self was participants' beliefs about the cause of their problematic drinking. In addition to between-participant variations in causal explanations, there was considerable within-participant variation, as reported in other studies examining personal understandings of addiction, e.g. (Christensen and Elmeland, 2015; Dingel *et al.*, 2017; Hammer *et al.*, 2012; Meurk *et al.*, 2016). In fact, no participant interview revealed a single, unified account; even when participants made strong assertions favouring one view, they proffered alternative conceptualisation(s) later in interview, often unwittingly. A good example of this is Daniel in Section 7.3.3 who stated he had *"absolutely no control over alcohol"* on the one hand, but later said *"a high percentage"* of his drinking was *"just pleasure or thrill-seeking".*

One possible explanation for apparent contradictions is exposure to numerous and often conflicting discourses from different treatment providers (Barnett *et al.*, 2017; Karasaki *et al.*, 2013; Savic and Lubman, 2018). Other studies which recruit through one community, such as 12-step groups or therapeutic recovery centres, tend to find "uniformity in the structure of narratives" (Kougiali *et al.,* 2017, p.12), which was generally the case for interviews with *Soberistas* members/browsers (Chapter 4). In the present study, participants with the most coherent narratives had usually been committed to one treatment philosophy for many years (e.g. *"the only way to stop drinking is AA",* Len), although this reflected just a small minority of the sample.

Individuals with no (or very limited) exposure to specialist treatment services provided interesting reflections on their relationship with alcohol as their responses to questions were unrehearsed. Marie, like several other participants, said she *"never had this type of conversation with anyone at*

all". Another participant even described the interview as being like *an "exam when you've never studied the subject matter"* (Steve) – he said*, "you're asking lots of questions that I have never really thought about; I am thinking about them as you're asking them".* However, further analysis suggested that even treatment-naïve participants had been exposed to numerous 'addiction' discourses via the media, their social networks, or during their hospital attendance/admission (Chapter 8), for example. These discourses might include an amalgamation of views from healthcare professionals, other people with lived experience, researchers and/or policy-makers; individuals are also found to hypothesise their own 'lay' explanations of dependence (Klingemann, 2011), sometimes developed through comparison to other drinkers (Hartney *et al.,* 2003; Khadjesari *et al.,* 2018).

In their examination of how neuroscientific concepts are integrated into understandings of self, Pickersgill et al. (2011) describe individuals as "bricoleurs" in that they "[assemble] frameworks for understanding personhood by piecing together different knowledges" (p.361). Analysis of my interview data revealed a similar process in that participants appeared to repeatedly negotiate and re-negotiate understanding of their alcohol use in relation to their 'self'; this was found to occur when individuals were presented with alternative views or encountered new experiences such as physical withdrawal (see Section 7.3.4) or an unscheduled hospital admission (Chapter 8), or when one conceptualisation was no longer considered helpful (see Section 9.2.2 in Chapter 9 for example). This process of ongoing negotiation was evident even *during* interview. When I asked Barbara her views of 'alcohol dependence as an illness', for example, she said: *"I have never looked at it that way, that has put a totally different perspective on it."*

Importantly, while several participants stated that understanding the cause of their drinking would help them take steps to address it (*"If I could understand why I am like I am, I'd be half way through my battle I think",* Daniel), many appeared disillusioned and frustrated in trying to make sense of their experiences within the context of multiple conflicting discourses. James, for example said:

> *"As far as I'm concerned, it's a whole major cluster fuck because there's people telling you one thing, people telling you another thing, other people telling you this, and then there's a poor person at the end, got a thumb up his bum, thumb down his throat thinking, well what do I do – I like my drink!"*

Thus, paying close attention to the process participants described going through in their efforts to establish a "coherent autobiography" (Bruner, 1991), reveals a confusing and stressful experience. Klingemann's (2011) study, which explored concepts of addiction from the perspectives of individuals in recovery from alcohol dependence in Poland, also found that individuals were

confronted with a conflict between professional definitions of addiction and their own; and this was especially salient for those who had received alcohol treatment. Pienaar and Dilkes-Frayne (2017) argue that in a climate of "dominating popular and therapeutic discourses" (p.153), researchers have a responsibility to explore and disseminate alternative narratives of addiction from the perspectives of those with lived experience. However, instead of taking versed narratives at 'face value', researches should evoke a more critical examination of participants' stories; an approach gaining momentum in recent years, e.g. (Barnett *et al.*, 2018; Fomiatti, Moore and Fraser, 2017; Savic *et al.*, 2017). As found in other research (Pienaar *et al.*, 2016), participants often attested to the "all-consuming nature" of alcohol dependence, but simultaneously provided examples of functioning in one or more life domains (workplace, leisure, home duties etc.). For example, even when Daniel said, *"you need bigger circles"* (referring to the PRISM, Section 7.3.3), he was still working a full-time job and managing his own flat. Only a few participants described occupying a *single* identity defined solely by alcohol, which supports the findings presented in Chapter 4 that identity is generally a multidimensional, or "crystallised", construct (Tracy and Trethewey, 2005).

However, dominant conceptual frameworks of addiction such as the disease model, which encourage a totalising 'alcoholic' identity, can usher individuals into narrating their experiences in such a way (Barnett *et al.*, 2018; Fomiatti, Moore and Fraser, 2017; Klingemann, 2011; Reinarman, 2005; Young, 2011b). Klingemann (2011) found that those engaged in alcohol treatment are "taught to reframe and conceptualise their problems 'properly'…the person learns how to talk like the therapist" (p.269-72). However, this conceptualisation might be at odds with personal experience. Trevor, for example, self-identified as an 'alcoholic' throughout interview, but when asked to elaborate on what that identity meant to him personally, it appeared to mean very little:

> *"Trevor: The whole way through the interview, yes, I have said I'm an 'alcoholic' because we're talking about 'alcoholics'.*
>
> *Interviewer: And what about when you are on your own – what do you think of yourself then?*
>
> *Trevor: I love myself, I do, honestly. I know that sounds fucking pretentious. When I'm on my own I don't actively or consciously think of myself as an 'alcoholic' then, no; I just think of myself as 'Trevor'."*

This changing expression of identity supports the construction of 'addict' identities as situationally and relationally dependent (Heim, 2014; Hughes, 2007; Neale, Nettleton and Pickering, 2011) – note that it was also Trevor who believed identifying as an 'alcoholic' benefitted his application

for welfare benefits (Section 7.4.2). Importantly however, many participants described 'identity fluidity', even 'off-stage' away from any audience (Goffman, 1959). This 'identity fluidity' may reflect the internalisation of a number of discourses discussed above. However, it also speaks to the narratives of many who were concerned about being forced to accept a life-long, unchangeable identity; Clive, who considers alcohol dependence as an illness that *"comes and goes"* (page 161), stated he *"can't subscribe to the idea that this is what you are, this is your pigeon hole, this is your label…labelling people is a dangerous thing to do, and I don't think it's necessary."*

Additional exploratory analysis of the two SOCRATES items relating to drinking identity provided some support for the notion of self-concept fluidity (Page 161). However, this analysis only considers changes in scores for the cohort as a whole, rather than changes at the individual level. Indeed, there were many individuals who retained the same score at both time points, which suggests identity stability; this was especially the case for those who either strongly agreed or disagreed to occupying an "alcoholic" identity. Nevertheless, it is still interesting to find statistically significant changes in median scores during the course of a relatively short-term study; although, caution must be exercised as these differences might be explained by measurement unreliability or regression to the mean effects. These findings may be enhanced by the careful development of a questionnaire(s) that incorporates a wider range of items to capture the diverse conceptualisations of drinking identity, as described by participants in this study and others. Further longitudinal work to track changes in drinking identity alongside changes in alcohol consumption, or other variables such as psychological dependence, would then be helpful.

In summary, the results presented in this chapter suggest that participants engaged in an ongoing, and at times apparently contradictory, assessment of their relationship with alcohol, and drew upon various strands of evidence (both implicit and explicit) to inform this process, including:

- their perceived levels of psychological dependence
- evidence of physical dependence on alcohol (including symptoms of withdrawal)
- discourses of addiction (encountered during treatment or elsewhere)
- the circumstances surrounding drinking behaviour (e.g. experience of adversity/trauma, or drinking for fun/pleasure)

Bruner (1991) argues that in order to maintain a "coherent autobiography", individuals must incorporate their experiences into a theory of self; new information or experiences demand re-evaluation. Participants in the present study appeared to be at different stages in their alcohol-related autobiographical journey, which triangulates the larger cohort's heterogeneous

characteristics, drinking histories and treatment experiences (Chapter 6). My findings contribute to a small but growing body of literature interested in alternative and multiple narratives of addiction and brings to focus the implications for identity construction and negotiation.

Chapter 8   QUALITATIVE RESULTS 2: ATTENDING HOSPITAL

8.1   Introduction

This chapter explores the impact of an unscheduled hospital attendance/admission on participants' conceptualisations of alcohol use and self. Analysis identified three key categories pertaining to participants' experiences of attending hospital; these are displayed in Figure 11 and are explored in turn:

1) **Hospital attendance as a "turning point"**
- "I had no idea the amount I was drinking could do that"
- Medical intervention: magic wands and scare tactics
- Biographical disruption: allowing "time to reflect"

2) **"It hasn't changed *who I am*"**
- "Back in the same old situation"
- Unwilling or unable to change

3) **The "revolving door"**
- Hospital attendance as a 'practice of addiction'
- Biographical *non*-disruption
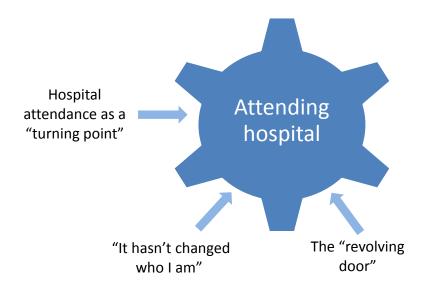
Figure 11:   The impact of attending hospital on conceptualisations of alcohol use and self

8.2   Hospital attendance as a "turning point"

This category examines participants' experience of hospital attendance/admission as a pivotal moment in changing how they conceptualised their relationship with alcohol; for some this meant a decision to reduce or stop drinking, for others it meant seeking alcohol-specific help for the first time. Many described attending hospital as a "turning point" which challenged taken-for-granted understandings of self and prompted behaviour change post-discharge.

8.2.1   "I had no idea the amount I was drinking could do that"

Several participants reported that hospital attendance marked the first realisation that alcohol intake had caused (in some cases serious and/or irreversible) physical harm:

> *"When it became reality that I had the starts of scarring [of the liver], when a doctor tells you that, it makes you think. I had no idea the amount I was drinking could do that…I mean that was a wakeup call when they said about the scarring. I don't want to die yet."* (Simon)

Individuals whose alcohol use was assessed for the first time in a hospital setting during recruitment to the study appeared especially affected by the news that their drinking had caused physical health problems. For example:

> *"Well I just couldn't believe it, you know? You just couldn't believe you could do that to yourself. It was a hell of a shock."* (Marie)

"That was the first time I had ever experienced [pain] like that, it was horrible. What the bloody hell was going on? It was a bit of a shocker to say the least. Then I started panicking, and they sent me straight through, I didn't even have to wait." (Lynn)

Although many participants could recall feeling unwell prior to hospital attendance, they often ignored earlier signs of ill-health or drank more to mask them. This observation aligns with findings of previous research that showed attempts to change consumption or seek help often occur after physical health problems become salient and severe (Simpson and Tucker, 2002; Webb *et al.*, 2007). Importantly, several participants said they *"didn't really associate [physical symptoms] with alcohol at the time"* (Joe); it was only with hindsight and knowledge learned during their hospital stay(s) that the effects of alcohol on the body were recognised. Joe continued: *"It was only really then [in hospital] that I knew there was a connection with my drinking, it was explained to me then."* Thus, attending hospital appeared to reinforce conceptualisations of heavy drinking as an embodied experience, even for those with no history of physical dependence or symptoms of withdrawal (Sinclair and Green, 2005). Lily, for example, described the impact of waking up in the emergency department (ED) and recognising for the first time the association between her deliberate self-harm and heavy alcohol use:

"After that last hospital admission, when I woke up, I looked at my arms and thought what the heck have I done? What the hell? I didn't know what happened. It made such a difference seeing what I had done like physically, like blood and cuts; they bandaged my whole arm."

Narratives of other participants extend the findings reported in Chapter 7 (Sections 7.3.3 and 7.3.4) that physical appearance provides information from which people construct their identity, by highlighting the role of attending hospital in this process. Steve, for example, said:

"I looked at myself in the mirror [in hospital], and I thought "where have you gone?" I just had a good look at myself. I was unfit, I had no strength, it was a shock."

Repeated medical interventions and discussions of alcohol use with healthcare staff strengthened the association between physical changes and participants' acceptance of their drinking as a contributing factor:

"In hospital they did every test under the sun; they said my blood counts were off the roof, over a thousand or something…I thought then, yep it's bound to be my liver, it's got to be my liver, hands up, I've done it…hospital can make people think twice about their actions, because some people don't realise how much it affects you." (Glen)

> *"I have more respect for alcohol having seen the effect it can have on my body…it was such*
> *a life opener, it really was. I thought, I'm not doing that again, I don't ever want to be in*
> *that position again."* (Gillian)

Interestingly, the narratives of individuals who did not perceive their hospital attendance to be alcohol-related, even when this contradicted hospital records, expressed less concern about addressing their alcohol use. For example:

> *"I guess there was a fleeting thought that I might not have fallen if I wasn't drinking so*
> *maybe I should stop, but then realised it wasn't because of alcohol that I fell over, and I*
> *don't want to stop."* (Robert)

This supports the role of individuals' attributions of physical illness/injury to alcohol use on their decision to reduce drinking, and ability to sustain ongoing change after discharge (Walton *et al.*, 2008; Williams *et al.*, 2010). Relying on physician assessment, rather than measuring whether participants attributed their hospital attendance to alcohol, may explain why there was no relationship between drinking outcome and whether participants had a 'direct alcohol-related admission' in the wider cohort study (Chapter 6).

8.2.2   Medical intervention: magic wands and scare tactics

Numerous participants described their hospital attendance as "hitting bottom" (Kirouac, Frohe and Witkiewitz, 2015) and illustrated this using the PRISM: *"I'd use the big disc yeh, right over me. Literally I was at my lowest point. It was just horrible"* (Lily). Several others also reflected on this period of their life as one of desperation and hopelessness. Barbara, for example, said, *"I couldn't really see a way out; I wanted to [stop drinking] but didn't really see how I could"*. Consequently, admission to hospital was often described as a *"relief"* in that it provided access to support and intervention from healthcare professionals, sometimes for the first time. Several participants said they were *"saved"* by hospital staff, with a few attributing their ongoing abstinence solely to the medical treatment they received:

> *"It was brilliant, honestly it was like a magic wand had been waved over me…I was saved by*
> *the intensive care people doing the detox…I didn't know that it had been done, or how it*
> *had been done, or even what it is."* (Graham)

Graham later explained that he had no desire to find out more information about his treatment in hospital but was just *"very glad they did what they did, even if they gave [him] a placebo or whatever"* because *"it worked"* in that he managed to remain abstinent. This supports research which finds that attending hospital can initiate change in alcohol consumption, regardless of the

intervention delivered (Bischof *et al.*, 2012; Owens *et al.*, 2016). Moreover, when participants lacked confidence in their ability to stop drinking (*"a mountain you can't climb"*, Rick), externalisation of control to medical experts appeared to facilitate a change in their relationship with alcohol. This aligns with research on locus of control theory (LOC, Rotter, 1966), which finds that in relation to health, patients with an external LOC are more likely to depend on medical professionals to intervene in their illness (Wallston, Strudler Wallston and DeVellis, 1978).

Being in hospital often increased awareness of mortality, which served as a *"wake-up call"* and prompted re-evaluation of alcohol use. Many participants recalled conversations with medical staff during their hospital admission about the seriousness of their physical health and the impact of continued drinking; participants often labelled these "scare tactics", known in the literature as 'fear appeals' (Peters, Ruiter and Kok, 2013; Witte, 1992). For example:

> *"My consultant said, 'I was very close to putting you into acute care, if you went into acute care you had a 50% chance of coming out. Next step down the line would be intensive care – that's a 5% chance of coming out'. He was laying it on the line for me. He was saying if you don't calm it down a bit, that's where I'll end up."* (Trevor)

> *"I went back into hospital with pancreatitis and the best thing a consultant ever said to me, he said: 'If you go out of here and drink, you'll come back into hospital and out again in a coffin'…the scare tactic worked."* (Luke)

The literature highlights several factors that determine the impact of receiving health information (including 'fear appeals') from medical professionals on behaviour change, which are relevant for findings in the present study. Firstly, patients who experience a first episode of acute ill-health are more likely to act on information from medical practitioners than those with chronic health problems (Kelly, 2015; Kelly and Barker, 2016); 'naïve' patients tend to rely more on experts to "remedy their deficiency in knowledge and understanding" (Kelly and Barker, 2016; p.4), whereas those with chronic conditions often become the expert of their own health. Learning for the first time the association between their heavy drinking and poor physical health appeared to be important for changing participants' conceptualisation of their relationship with alcohol in the present study (see Chapter 7). This triangulates the quantitative results presented in Chapter 6 which suggest that participant experience of a first hospital admission in which alcohol use was discussed, is associated with a favourable dependence outcome at six months (after controlling for baseline levels of consumption).

Another factor identified in the literature concerns levels of perceived self-efficacy to change behaviour (Peters, Ruiter and Kok, 2013; Witte, 1992). When participants described being

confident they could reduce/stop their alcohol consumption and believed doing so would prolong life or improve health, provision of feedback about health status appeared to be a springboard for behaviour change. For example:

> *"Jack: I tell you what one of my main motivators was, I thought I had been given a second chance because when I had an ultrasound, the jelly belly thing, they tested my liver functioning and I said, 'right, what's the damage then nurse, tell me straight?', and she goes, 'basically, we done one on you two years ago and it's the same as it was back then'. I was thinking, how can that be right? You need to put your glasses on girl! My liver is a little bit fatty but basically, it's not fucked, you know?*
>
> ***Interviewer: And how did that make you feel, hearing that?***
>
> *Jack: That I've got a second chance. It made me motivated. I think that's what gave me the boot up the arse…getting some good news has elevated me."*

When asked what his response would have been to bad news about his liver function, Jack said: *"I would have gone the other way and probably thought 'fuck it'…if I was going to die, I might as well make it happen quicker to save the agony".* Several others agreed that if they could not envisage that behaviour change would alter the course of poor health, fear appeals might cause them to *"push the 'fuck it' button"* (Daniel). Moreover, other qualitative work has found that conversations with medical staff focusing on the connection between heavy alcohol use and risk of serious ill-health or death can sometimes alienate patients and block the development of a therapeutic relationship (Clark *et al.*, 2017); this is a poignant finding because therapeutic alliance is considered an important variable in the behaviour change process (Meier, Barrowclough and Donmall, 2005; Miller and Moyers, 2015). However, other research has found limited support for therapeutic alliance predicting drinking outcomes in medical inpatients, hypothesised because of short (often single) encounters (Bertholet *et al.*, 2014). In the present study, many participants felt medical professionals had a duty to *"tell it as it is",* and agreed with Clive who said, *"I absolutely do not feel medics should tip-toe around…out of fear of offending the person".* In fact, several said they believed upfront conversations, which may be perceived as detrimental to building therapeutic alliance (Clark *et al.*, 2017; McCallum *et al.*, 2016), were the most effective intervention for changing behaviour:

> *"The consultant came around and he said, 'I'm not here to bullshit you. I don't think you're into this 'namby pamby' bullshit crap: your next drink – you're dead'. I went, 'what?' He said, 'your next drink, you're dead. No crap, this ain't going to take long. You keep drinking, you're dead. As a matter of fact, if you want to drink, phone the coroner and make all the*

arrangements while you're sober so it will save you the bother while you're pissed'. And I went, right that's it. Compassion never works, never worked with me. I like people who don't bullshit. Say it the way it is and how it is, don't pull no punches. If it's going to happen, tell me it's going to fucking happen." (Nathan)

Although this direct approach may not be universally effective (Peters, Ruiter and Kok, 2013; Witte, 1992), participants were in overwhelming agreement that it *"doesn't hurt anybody to have a chat"* (Glen), and were receptive to interventions in hospital for people with AUD. This even applied to those who did not want to change their drinking, like Robert:

"They used to come and talk to me about alcohol…it didn't make me change my thinking or anything. It doesn't offend me that people might try to help…someone has got to do that in case people do want help…I guess it is [helpful] to some. Is it helpful to me? Don't know, probably not, but it didn't worry me having a chat."

These findings, together with observations that alcohol-dependent hospitalised patients report greater motivation to address their drinking than alcohol-dependent individuals in the general population (Rumpf *et al.*, 1999), emphasise hospital admission as a promising "teachable moment" in which individuals may be receptive to advice about altering their drinking behaviour (Chick, Lloyd and Crombie, 1985; Lau *et al.*, 2010; Roper *et al.*, 2013; Williams *et al.*, 2010). Moreover, several authors have documented the adverse impact of stigma on treatment seeking, e.g. (Keyes *et al.*, 2010; McCallum *et al.*, 2016; Probst *et al.*, 2015), and numerous participants agreed with Milo that *"it's the asking for help bit that we struggle with most…the shame of it"*. Thus, even though the evidence base for hospital alcohol interventions is limited (Field *et al.*, 2010; Glass *et al.*, 2015; McCambridge, 2011; McQueen *et al.*, 2011; Mdege *et al.*, 2013; Simioni, Cottencin and Rolland, 2015), my data support the acceptability of discussions about alcohol in this setting (also see Section 6.3.3 in Chapter 6 for participants' quantitative ratings of their assessment). So long as discussions of alcohol use were respectful and discrete, participants did not describe any harm resulting from them, and echoed Jack's reflection that *"even if it helps a handful of people, it's got to be worth it, isn't it?"*

8.2.3   Biographical disruption: allowing time to reflect

Bury's (1982) concept of "biographical disruption" provides a helpful lens through which to understand the interpretation of hospital admission as a 'turning point'. Significant life events, such as being diagnosed with a chronic illness, can be viewed as disturbances to the continuity of one's biography in that they demand re-evaluation of selfhood, engrained behaviours, and social/material resources (Bury, 1982). This theory builds on the observation that "we can learn a

good deal about day-to-day situations in routine settings from analysing circumstances in which those settings are radically disturbed" (Giddens, 1979, p.123). Participants frequently said hospital admission marked a "turning point" because it afforded them time to reflect on their relationship with alcohol and evaluate wider life goals; it was in essence, a biographical disruption. Indeed, the results of a recent international online survey of >72,000 respondents from the general population found that across all countries, experience of physical health problems and seeking emergency medical treatment were among the top three rated reasons for considering change in drinking behaviour (Davies *et al.*, 2017).

Respite from the daily routine of alcohol consumption to allow *"thinking space"* (Simon) was highlighted as a positive by-product of hospital attendance more often than restoration of physical health, which for some participants appeared to be an afterthought: *"the time in there…I didn't have to think about anything or worry about anything apart from my drinking, oh and my health obviously"* (Howard). Discussions with healthcare staff also helped some individuals to see their relationship with alcohol in a new light, especially if they had never had the opportunity to speak to anyone about their alcohol use before, or experienced adverse alcohol-related harms: *"It made it clearer – helped file it all into files in my head…I don't speak to anyone about it"* (Marie). This aligns with Williams et al.'s (2010) work which found that individuals with an alcohol-attributable hospital attendance had better drinking outcomes at three months, but only if they reported non-dependent unhealthy alcohol use and low awareness of their drinking as a problem. These factors might therefore contribute to the significance of hospital attendance as a "biographical disruption" and serve as a catalyst for change.

The psychological break that hospital admission provided often symbolised the start of a new life chapter for many participants, even if they resumed drinking post-discharge. Jack's reference to his "previous life" before his hospital admission explicates this particularly well:

> *"It gave me time to reflect on my previous life, gave me a lot of time to stare at the walls. All you've got is your memories, and it gave me time to think about my life, times that have gone by, and I realised it's about time I knocked this shit on the head basically."*

Roper et al. (2013) suggest that unplanned "mirroring events", such as attending hospital, are particularly powerful precursors to change as they starkly reflect back to individuals the reality of their drinking and demand identity re-evaluation – see also: (McQueen, Ballinger and Howe, 2017). Consequently, individuals may move from 'pre-contemplation' straight to 'action' stages of change rather than progress through the stages in an orderly fashion, as hypothesised by the transtheoretical model, TTM (Prochaska and DiClemente, 1983). An important realisation for

participants in the present study was the impact of them being in hospital and the consequences of continued alcohol consumption on loved ones. Lynn, for example, said:

> *"The first thing I thought of was my grandkids and my daughter, and my family, my sister. I have a family that care and love me. I felt sad that I had been so selfish; I was drinking because my parents died, but I'd leave my daughter in the same situation if I killed myself with the booze."*

This also supports work which finds that high levels of 'social capital' (Granfield and Cloud, 2001) are conducive for recovery, and the "knock-on effects" of health problems, such as fear of not seeing children grow up, are often more important in determining change than experience of health problems per se (Webb *et al.*, 2007). These findings also highlight that the individual's *appraisal* of turning point events are what determine their impact (Kearney and O'sullivan, 2003; Sobell *et al.*, 1993).

Numerous participants emphasised that hospital attendance had more impact on changing their thoughts about alcohol as the duration of stay increased. Many explained that longer admissions disrupted entrenched routines of heavy alcohol consumption (see Section 7.3.3 in Chapter 7) in a way that ED attendance or shorter admissions could not; in rationalising this, participants often alluded to the benefits of detoxification, which can take 7-10 days to complete (Day, Copello and Hull, 2015), for clarity of thinking:

> *"Well apart from detoxing, that's the main thing of course. You definitely need a detox…convalesce."* (Milo)

> *"Being in hospital and getting 'detoxed' just gives you space to think without the alcohol fog – you can't clearly think and decide what you want intoxicated."* (Joe)

This finding resonates with other qualitative work which found that participants valued hospitalisation as it "broke the cycle of drinking" (McCallum *et al.*, 2016, p.834). Although evidence for unscheduled alcohol detoxification is mixed (Azuar *et al.*, 2016; Berg and Dhopesh, 1996), one study found that being detoxified at the time alcohol interventions were delivered, was associated with more favourable outcomes six months post discharge (Rochat *et al.*, 2004). Furthermore, participants in the present study said the hospital environment increased their self-efficacy to sustain abstinence after discharge because it *"makes sure you can't get to alcohol for a little while and reminds you that it's not actually a big deal, you can be without it"* (Lorna). Indeed, several others said they would have likely continued to drink if they were discharged sooner*: "I was in hospital nearly 3 weeks I think so it was that long hospital stay that helped maybe…had they have let me out after 2 or 3 days, I might have carried on actually."* (Lynn). Interestingly,

Lynn's comment speaks to a memo I wrote following the initial (quantitative) interview conducted during her hospital stay (see Box 3).

Box 3: Memo following baseline (quantitative) interview with participant 'Lynn'

I had to complete the interview in two stages (2 weeks apart) as Lynn was too unwell at the start of her admission to complete in one session. When I first saw her, she said her drinking isn't a problem – she "only drinks a bottle of Lambrini wine 4 or 5 days a week" – and she hasn't thought about giving it up or cutting down. However, Lynn was visibly withdrawing from alcohol when I first met her, suggesting higher levels of intake (which she confirmed during our second meeting where she reported drinking 4.5 litres of Lambrini wine daily). She appeared much more concerned and reflective about her relationship with alcohol the second time I met her; she even affirmed a strong commitment to stop drinking altogether. Such a change in 2 weeks!

This example highlights the change in individuals' ability/willingness to reflect on their relationship with alcohol and motivation to address drinking, as a function of length of admission. Other studies which completed within-participant repeated measures of motivation to change alcohol or other drug use also reported significant increases during medical inpatient stays (D'Souza and Mathai, 2017; Pollini *et al.*, 2006). While quantitative measures were not repeated during participants' hospital stay in this study, an exploratory comparison of self-reported motivation between individuals who only attended ED and those admitted to hospital, suggests a similar picture: those only attending ED had significantly lower 'taking action' scores on the SOCRATES than individuals who were admitted to a ward (U = 1366.5, z = -2.99, p=.003).

Qualitative narratives suggest that longer hospital stays resulted in greater biographical disruption potentially because individuals had more time to re-negotiate their drinking-related identity, away from the influence of everyday routines. They also had greater exposure to medical interventions and staff interaction concerning their alcohol use, which in some cases strengthened the perceived association between participants' ill-health and their acceptance of their drinking as a problem (see Sections 8.2.1 and 8.2.2 above). Importantly, this renegotiation could occur without the *"alcohol fog"* clouding decision-making. Examples of participants who only attended ED, like Aaron below, affirm this finding:

"Aaron: When I am in the hospital I think, 'I can't wait to get home in the morning because I know I've got half a bottle of cider left'. You wanted me to be honest.

Interviewer: I really appreciate you being honest, thank you. Can you explain why you think like that?

Aaron: Because it's [alcohol] in my system still. Like when I wake up in A&E in the morning, it's in my system, and if I know I've got alcohol there, I will drink it. Not because I need it, but I want it, just because it's there."

8.3 Hospital attendance "hasn't changed *who I am*"

The second category explores incidents where hospital attendance was reported to have a limited impact on individuals' drinking behaviour. Analysis was enhanced by the narratives of participants who had favourable drinking outcomes in the present study (Chapter 6) but had experienced previous hospital admissions that did not prompt behaviour change. Two main categories were identified which highlight the challenges of returning to the home milieu, and situations where individuals were either unwilling or unable to engage in conversations about their alcohol use in hospital.

8.3.1 "Back in the same old situation"

While most participants attested to the benefit of hospital admission for providing respite and time for reflection (see Section 8.2.3), several noted the difficulty in transitioning back to a home environment not conducive for ongoing change. Patients with AUD who attend hospital often have multiple and complex needs that extend beyond problematic drinking (Neale *et al.*, 2017), and hospitalisation is rarely able to address these factors, which can perpetuate substance use (Clark *et al.*, 2017; Raven *et al.*, 2010; Velez *et al.*, 2017). Nathan's story illustrates this clearly; he was detoxified in hospital, but due to homelessness, had to accept residence at a 'wet house' which operated a scheduled drinking programme. He explained the impact this had on him:

"I wasn't even thinking about drink. That was the last thing on my mind, but once I saw it, there it goes in my mind. I have just been detoxed and given 4 cans; what the fuck? Why have they put me in here for?"

The presence of external factors that impede one's ability to change, such as unsuitable accommodation, might explain why participants' baseline level of readiness to change was not associated with drinking outcome at six months, but their living situation was (Section 6.5.1 in Chapter 6). This also challenges the traditionally endorsed importance of 'motivation', reported in

previous hospital-based studies, e.g. (Bertholet *et al.*, 2010; Bertholet *et al.*, 2009b; Freyer-Adam *et al.*, 2010). Marie, for example, scored 29/30 on the "taking steps" subscale and 44/50 on the "problem perception" subscale of the SOCRATES, indicating very high levels of readiness to change at baseline; however, she continued to drink at high levels after discharge, and even reported intensifying psychological dependence. In explaining why, she said:

> *"You say all these things to yourself in hospital about how you're not going to drink again but when I got home, I started again. I can't help but think that when you are back in an environment that isn't particularly good for you, you just change back to your old ways, I'm sorry you do…you are back in the same old situation and you go back to your old ways…all the ideas you had in hospital just go out the window and you're back to square one again. I am surprised you know, since I broke my back, that I have continued drinking, that surprised me."*

This excerpt highlights the disjuncture between hospital-based motivation/intention and behaviour change after discharge and echoes the experiences of several others*: "I said to you at the time that I'm not going to drink again, and it didn't happen"* (Clive). Her narrative also provides another reminder that sustained recovery is often dependent on "the willingness of others to engage in, and support, such change" (Hughes, 2007, p.688); like several other participants who did not reduce their drinking to the level they intended, Marie described having limited social support, and cited loneliness as a key reason for ongoing consumption, as emphasised by Åkerlind and Hörnquist (1992). Thus, being re-confronted with the same social and environmental context within which participants used to consume alcohol, adversely impacted on progress made during hospital, and corroborates other qualitative research (Clark *et al.*, 2017; Gibson, Acquah and Robinson, 2004; Velez *et al.*, 2017).

Another common theme was that as participants' memory of hospital admission faded, so did their recognition of alcohol as a problem. For example:

> **Interviewer: Did being in there change your thoughts about drinking?**
>
> *Trevor: Initially yes, it made me think, 'curtail it, slow it down a bit'*
>
> **Interviewer: And did you?**
>
> *Trevor: No. After about a week, how shall I put it? Relapse – 'oh I'm better now'."*

Extending Trevor's point, several participants explained that improvements in physical health made less salient the need to maintain abstinence. For example, Daniel, who I interviewed during a subsequent alcohol-related hospital admission, said:

> *"Two or three days ago I felt like death, I really felt like I was on my way out. Now I feel great. I have already lost the feeling and memory of how bad it can be, you know this is only two days ago, I'm still sat here in the bloody hospital…because of the Pabrinex they give you and all the vitamins, you actually come out of here feeling healthier than you do in general day life."*

Thus, even if hospital attendance resulted in 'biographical disruption' (Bury, 1982), when its consequences were temporary, individuals appeared more vulnerable to relapse. A few participants described techniques, such as keeping their hospital discharge summary somewhere visible, to retain the memory of *"how bad it was"*. This seemed to work as a deterrent from drinking for some individuals, including Howard, who deliberately kept his hospital wristbands on after discharge. However, he continued to say: *"I gave up [alcohol] for 56 days…it was only when they fell off I went back on it…they only detoxed me; hospital hasn't changed who I am"*. Meaningful integration of hospital as a disruptive event into one's *ongoing* biographical identity therefore seemed important for sustained behaviour change; further work is needed to refine understanding about how this can be achieved.

However, disjointed pathways between hospitalisation and longer-term treatment and follow-up were said to undermine this process and reflects the fragmented nature of alcohol treatment systems internationally (Gilburt, Drummond and Sinclair, 2015; Raven *et al.*, 2010; Rivest, Jutras-Aswad and Shapiro, 2013). Jack, for example, was given an appointment to attend community treatment services by hospital staff but was turned away because the substance misuse worker was on annual leave:

> *"I was supposed to go down to [community treatment services], but they stitched me up. I did make the effort, but the guy was on annual leave. Don't see why they would have made an appointment for me if he was on annual leave. But no discredit to the man, he got mixed messages."*

Jack said he had not returned to treatment services, supporting the notion that "the window of opportunity" in which individuals are responsive to intervention is often limited (Roper *et al.,* 2013). Examples of effective multi-agency working from my data and other hospital-based literature (Rochat *et al.*, 2004; Simioni, Cottencin and Rolland, 2015), reinforce its importance for favourable drinking outcomes and subsequent treatment utilisation, even if only for individuals "gravely disabled by alcohol use disorders" who often require ongoing support (McCormack *et al.*, 2013):

> *"If it wasn't for these alcohol nurses referring me to [community treatment services], and people like yourself working in this environment, I think there would be more people passed away unfortunately, and it would have been me, because I think I would still have been on the drink."* (Luke)

8.3.2 Unwilling or unable to engage

Some participants recalled occasions where they were unwilling and/or unable to engage in discussions about their alcohol use during hospital stay(s), restricting the "window of opportunity" for staff to offer support and advice (Roper *et al.,* 2013). The most commonly discussed barrier for non-engagement was reluctance to change, often driven by perceived benefits of continued drinking (see Section 7.4.4 in Chapter 7) or lack of acceptance of alcohol use as a problem:

> *"I didn't want to see anyone [in hospital]. In my eyes, I thought I didn't really have a problem…well I knew deep down I needed help with [drinking] but pretending to myself I didn't, especially 'cause alcohol was helping to a certain extent."* (Lily)

Some participants said they became *"good at giving the right answers"* (Rick) and told people *"what they want[ed] to hear"* (Lee) to speed-up discharge (and possibly a research interview!):

> *"They always give advice, but once I am there, sober, in the morning, I just want to go and drink what I've got left at home. So, if I'm honest, I just, whoever I am talking to at that time, I just say what I need to say to please them, so I can be discharged."* (Aaron)

Only a minority said the attitudes of some healthcare staff towards patients with AUD undermined the potential impact of interventions (NB: these were mainly comments from individuals, often labelled as "frequent alcohol attenders" or "frequent flyers" (Neale *et al.*, 2017; Ward and Holmes, 2014), who reported numerous alcohol-related hospital attendances; see Section 8.4 below). Feedback about staff was generally positive and highlighted their caring and non-judgemental approach:

> *"The staff were lovely, you couldn't wish for anyone better."* (Lynn)

> *"I was never made to feel bad…nobody has pre-judged. Maybe they do in their minds, I don't know, but the hospital was just brilliant."* (Graham)

> *"I can't speak highly enough of every single member of staff…the respect with which each individual is treated is second to none, it really is. It made no difference to them that I needed some treatment for alcohol."* (Clive)

This contrasts with other hospital-based research findings in which many participants described feeling stigmatised by professionals (McCallum *et al.*, 2016; Velez *et al.*, 2017) and with studies that reveal negative attitudes of healthcare staff towards individuals with substance use disorders (van Boekel *et al.*, 2013). In the present study, participants were much more likely to describe self-stigma (Matthews, Dwyer and Snoek, 2017; Schomerus *et al.*, 2011b) and many expressed concerns about *"wasting NHS resources",* especially if they reported several alcohol-related hospital attendances. Self-defamatory statements often stemmed from assumptions about AUD being the product of "moral failing" (Heather, 2017):

> *"Barbara: Several times I have been in hospital, and I hate myself for that because to me it feels like I am taking up a bed and I am wasting the doctor's time because there are people who are really sick out there.*
>
> *Interviewer: So were you.*
>
> *Barbara: But it was my fault, it was self-inflicted."*

Feeling undeserving of help was therefore a barrier to engaging in discussions relating to alcohol use, even if staff presented as empathetic and displayed genuine regard. Roper et al. (2013) warn of the possibility that "mirroring events" can generate an intolerable self-image because they draw to attention unfavourable aspects of self; the authors suggest that one method for resolving this dissonance is to reject the need to change, thereby minimising the impact of hospital attendance as a "turning point".

Other participants reported incidents of being "ready and willing, but unable" (Kelly *et al.*, 2012b, p.227) to engage in discussions about their problematic drinking because of ill-health, emotional distress, or acute physical withdrawal:

> *"I was on a different planet, I was having all these hallucinations…I couldn't understand what was happening; I couldn't stop it and I couldn't communicate with people. It was awful."* (Simon).

Consequently, several described hospital attendance as a "blur". Even those with lengthier admissions, like Graham whose stay was 29 days long, reported patchy recollection of their time in hospital: *"I can remember some things but not others. It was confusing. I wasn't even 100% when I was discharged."*

Several participants also spoke to evidence in the literature that physically dependent individuals often exhibit impaired cognitive functioning (Le Berre, Fama and Sullivan, 2017). James, for example, said:

> *"Half the time I couldn't remember, erm, you have to imagine that after a while your brain*
> *does get a bit soaked if you're drinking all the time, and you don't rest up and take normal*
> *fluids. Yeh, you do get sodden."*

Not only does cognitive impairment reduce the ability to engage in meaningful assessment/discussion of alcohol use, it has also been found to impede motivation to change (Clark *et al.*, 2017; Le Berre *et al.*, 2012). While abstinence can improve cognitive functioning (Le Berre, Fama and Sullivan, 2017), short hospital stays are likely to be insufficient, and do not provide time for self-reflection without the *"alcohol fog"* (Joe; see Section 8.2.3 above). Furthermore, hospital attendees, like those in the present study, have the additional challenge of managing complex physical health needs.

8.4   The "revolving door"

Commonly referred to as "alcohol frequent attendees", "frequent flyers", or "high impact users" (Neale *et al.*, 2017; Ward and Holmes, 2014), a few participants described experience of repeated alcohol-related hospital attendances. Analysis of their accounts revealed distinct patterns of identity construction which contrasted with individuals who had minimal experience of attending hospital.

8.4.1   Hospital attendance as a 'practice of addiction'

For a few individuals, attending hospital appeared to become enmeshed not only with their steady routines of drinking, but with their definitions of self, extending the findings presented in Chapter 7 (Section 7.3.3). Using terminology often found in mental health literature, Daniel commented:

> *"My whole life was based around being asleep, drinking, going to hospital, detoxing…I guess*
> *am what you would call a 'revolving door' patient…I do use the system a little bit too much."*

In discussing the 'revolving door syndrome', Appelbaum (2001) explains:

> "Admitted to a psychiatric inpatient facility, this patient often re-compensates quickly in
> response to psychotropic medications, removal of access to intoxicating substances, and
> the structure provided by ward routine. Once discharged, however, he or she stops taking
> medications, drifts away from outpatient care, frequently resumes substance abuse, and
> soon appears at the hospital door, requiring admission once again. The cycle can be
> repeated three, four, ten, or 20 times in a year." (p.348)

Participants who reported a pattern like that described above, explained how regular *"little trips to the hospital"* (Donna) became an anticipated consequence of their drinking. Donna continued:

> *"It has become more of a 'normal' thing for me, whereas to begin with you react with shock-horror, 'what am I doing here?' Whereas I got to the stage where I was like, 'oh look, I'm here again'."*

The experiences of participants like Donna, and Daniel above, resonate with Hughes' (2007) work on "practices of addiction" in which behaviour associated with one's drinking (e.g. attending hospital) becomes synonymous with identity (e.g. an "alcoholic" or "revolving door patient"). In other words, what one does defines who one is. Moreover, when addiction is understood as inseparable from wider social, political, and environmental contexts (Heim, 2014; Hughes, 2007; Neale, Nettleton and Pickering, 2011), one can understand how engagement with healthcare professionals in hospital can reinforce this view of self:

> *"I mean at one stage, in one year, I was admitted 26 times…you go in again and they say, 'oh it's you again, still haven't given up then?' Well, no."* (James)

Another participant even described occasions where he felt he needed urgent medical attention but refused to attend hospital for fear of *"getting a reputation"* (Howard):

> *"How many times are you going to go into hospital, how many times are people going to have to help you? Eventually they will go, 'oh it's that fucking drunk again, let's get rid of him'."*

Perceptions that individuals who repeatedly attend hospital for alcohol-related reasons are "problem patients" or a "drain" on resources, along with use of labels such as "frequent flyer", can fuel stereotyping and stigmatisation (Neale *et al.*, 2017; Robinson, 2016). The adverse consequences of internalising such stereotypes (i.e. 'self-stigma') are highlighted in the literature and include diminished self-respect and motivation to achieve personal goals (Corrigan *et al.*, 2016), and lowered drinking-refusal self-efficacy (Schomerus *et al.*, 2011b). Moreover, research finds that negative perceptions of individuals with alcohol/substance use disorders can result in sub-optimal healthcare (van Boekel *et al.*, 2013; Wise-Harris *et al.*, 2017); indeed, participants in my study explained that their complex and varied needs were often neglected at the expense of focus on 'loud' symptoms such as intoxication:

> *"I don't know whether [my drinking] was because of the break-up, just feeling low, depressed, shitty about work, hated work, and everything else. But again, no-one gives a shit about all that, they only cared about how much I was drinking."* (James)

Emerging evidence for the effectiveness of interventions designed to reduce repeated hospital attendances, including case management and individualised care plans (Hughes *et al.*, 2013; Rivest, Jutras-Aswad and Shapiro, 2013; Soril *et al.*, 2015), support the role of person-centred holistic approaches. Participant examples where such support was not available, highlight how failure to understand the drivers of problematic drinking and repeated hospital attendance can serve to maintain them. Lee, an army Veteran, for example, was only diagnosed with posttraumatic stress disorder (PTSD) and referred to specialist support services after his new manager *"noticed something [was] wrong"*:

> *"I need to be careful not to point blame really…but it's taken people at work who are not medically trained in any way…to look at me, notice something is wrong and say 'we need send to send you somewhere for help' – and they had only known me for weeks…but nobody in hospital has picked up on the fact, why? They just accept the fact that I am an 'alcoholic' and I am going to keep coming back, but nobody has asked 'why?' Whatever the reason is, possibly money, and I understand that, you know? Although had they had found out why from admission 1, 2 or 3, I might not be sat here now with 40 plus admissions on my record."*

Other authors have noted that repeated 'failures' to change can increase use of, and attachment to, drinking (Orford, 2001; Webb *et al.*, 2007). This is supported by additional analysis of the wider cohort data (Chapter 6) in that participants who reported previous assessments of their alcohol use in hospital (i.e. they experienced successive 'failures') had significantly higher levels of psychological dependence (median LDQ score 24 vs. 14; $p<.001$) and alcohol consumption (median past-week unit consumption 140 vs. 94; $p<.01$), than those who were assessed for the first time; they were also more likely to have an unfavourable outcome in level of psychological dependence at six months (Section 6.5 in Chapter 6). Qualitative data suggest that repeated hospital attendances became entwined with the *"accepted inevitability"* of heavy drinking, typically found in those with severe physical dependence (Section 7.3.4 in Chapter 7):

> *"If we were to both put 10 pounds on the table now and you said, 'I bet you're going to go in hospital this year', I'd agree and say, 'I bet I do'. I'm under no misconception that this isn't going to happen again which is horrible."* (Daniel)

8.4.2 Biographical *non*-disruption

Individuals who reported numerous hospital admissions eventually experienced them as *non-*disruptive to their continued biography (Bury, 1982), and contrasts with the narratives described

earlier (Section 8.2.3). One explanation for this, is that hospital attendance was anticipated (in some cases planned), and therefore lacked the 'shock factor' described by other participants:

"I knew I was going to end up in hospital – I did know, when I picked up that glass, I knew I was heading for the hangman's rope, I knew it. It wasn't a shock or a wake-up call." (Len)

Len also explained that hospital staff *"couldn't tell [him] anything [he] didn't already know"* which differs to the accounts of 'naïve' participants who relied on professionals to help them make sense of their situation (Section 8.2.2).

Despite actual or feared stigmatisation as a "frequent flyer", participants described hospital as a "safe place" that provided respite from heavy drinking and painful physical withdrawal. This safety acted as a 'pull' factor drawing individuals to hospital (Parkman *et al.*, 2017a):

"I feel safe when I'm there. I wouldn't have felt that if I were at home at that sort of painful stage [of drinking], so emotionally, yeh, I felt safe…it's never been anywhere that has been scary." (Donna)

Others found safety in not having to hide their drinking identity. Daniel, for example, said that except from his mother, no-one in his life knew about his problematic relationship with alcohol:

"I come here [hospital], and people recognise me and say, 'oh you're back in then?' They know exactly what my life's all about and I'm quite content with that."

The contentment Daniel describes in not having to 'act a performance' when in hospital (Goffman, 1959), echoes the accounts of *Soberistas* users who felt relief in honestly sharing their difficulties with alcohol via an anonymous online platform (Chambers *et al.,* 2017). However, for Daniel, the ability to 'close the door' on his alcohol-related identity when he was discharged from hospital, appeared to increase his vulnerability to relapse. This also supports the benefits of accountability for sustained change (Chambers *et al.*, 2017; Webb *et al.*, 2007; Witbrodt *et al.*, 2012), which may be especially important during early recovery (Tonigan and Rice, 2010).

Parkman et al. (2017a) found that positive experiences of, and beliefs about, hospital care were key reasons why people attend ED frequently. Like my participants, they were 'pulled' by the safety of familiar staff who knew their personal histories and could offer immediate help, often with free tea and sandwiches. However, the authors also identified factors that 'push' individuals into attending hospital, including inadequate support within community treatment services. This resonates with my data. For example, Joe explained that he was placed on a waiting list for an appointment at his local community alcohol service but *"needed something immediately"* and so presented to hospital:

> *"I knew I needed help. So, I almost force-drank myself into hospital. I went up to A&E, they*
> *discharged me within 2 hours. So, I went home, drank more, and then went back to hospital*
> *and they kept me in for a couple of nights…I just thought, 'I need to make myself really ill. I*
> *know I need help, but I just seemed to have been told to go home'. Right ok, I will just try*
> *harder."*

Even though individuals were often quickly discharged and *"just referred back to the community*
service place" (Howard), receiving good-quality care and respite, even for a few hours, appeared
to temporarily satisfy a need for help:

> *"A lot of it is me getting pissed, getting down, threatening to kill myself, jump off a bridge. I*
> *ring my friends and they call an ambulance. I have done that quite a few times...I think it's*
> *more for the attention to be honest…a cry for help. But in the morning…once I have sobered*
> *up and that, I feel I'm fine and don't need to be there."* (Aaron)

Positive hospital experiences therefore increase the 'attractiveness' of attending again in the
future and may reduce the need to engage with specialist services (Parkman *et al.*, 2017a; Raven
et al., 2010; Wise-Harris *et al.*, 2017). Importantly however, qualitative work has found that most
people who frequently attend ED for alcohol-related reasons do not want help with their alcohol
use, but rather require support for problems associated with poor mental health, social
circumstances, housing, or finances (Parkman *et al.,* 2017b). These findings, alongside my own,
explain why attending hospital is not always experienced as a biographical *disruption* (Bury, 1982)
demanding re-evaluation of one's relationship with alcohol. For a few participants, repeated
exposure to the hospital environment became incorporated into their "coherent autobiography"
(Bruner, 1991); it was only when attending hospital became a qualitatively different experience,
that it disrupted their sense of self, as Daniel's example highlights:

> *"This week shocked me actually because it has always been like…I know I can get to*
> *oblivion, and I can come here, and these guys are going to save me, erm. But the shock*
> *factor for me this week is, a) they have taken a bit more interest in me, and b) they have*
> *given me more, different medicines than they normally give me. So, I was a little bit sort of*
> *emotional yesterday, so I don't know if that's been a kick up the arse sort of thing."*

8.5   Summary

Previous researchers have suggested that the relative impact of "turning point" events is largely
determined by the self-appraisal that follows (Kearney and O'sullivan, 2003; Sobell *et al.*, 1993).
Participants who experienced their hospital attendance as a 'biographical disruption' (Bury, 1982)

said they valued time away from daily routines and responsibilities to reflect, re-evaluate their priorities, and establish the place of alcohol in their lives going forward. Making alcohol use salient as an embodied experience through medical interventions, discussion with healthcare professionals, and seeing/feeling physical changes, also appeared crucial to this process. These results support hospital attendance as a possible "mirroring event" (Roper *et al.,* 2013) that prompts reflections of both self and physical body.

Having one's alcohol use assessed in hospital for the first time was described as particularly 'disruptive' and supports the regression analyses in Chapter 6. Participants were often "shocked" to learn of the harms associated with their drinking and cited this unanticipated realisation as a primary reason for changing their relationship with alcohol; this finding adds to evidence questioning whether individuals need to be 'psychologically prepared' for change, e.g. (Roper *et al.*, 2013; Sobell, Ellingstad and Sobell, 2000; Walters, 2000). Furthermore, participants with first-time assessments were significantly more likely to be treatment-naïve, making hospital attendance the first ever opportunity for some to talk about their use of alcohol. Given the barriers to specialist treatment access post-hospital discharge (Cucciare and Timko, 2015; Glass *et al.*, 2015; Lid *et al.*, 2012; Parkman *et al.*, 2017b; Raven *et al.*, 2010) and more generally (Gilburt, Drummond and Sinclair, 2015; Keyes *et al.*, 2010), it is recommended that healthcare staff maximise the "window of opportunity" that hospital attendance affords to engage patients with AUD in supportive discussions about their drinking (Roper *et al.,* 2013). As the impact of first-time alcohol assessments in a hospital setting is unexplored territory until now, clearly these findings require further investigation.

Analysis of qualitative accounts revealed numerous factors that appeared detrimental to the consolidation of hospital as a 'biographical disruption', which may help to explain differing participant trajectories post-discharge. Key factors included: short hospital stays, not being detoxified, severe physical illness (and lack of belief that changing drinking behaviour would alter its course), cognitive impairment, failing to attribute one's hospital attendance to heavy alcohol use, an unsupportive home milieu post-discharge, self-stigma, and limited self-efficacy to change. Frequent alcohol-related hospital attendances also reduced the likelihood of 'biographical disruption'; participants often described hopelessness and high levels of self-stigma, with every admission perceived as another 'failure'. Moreover, although not commonly reported by participants in the present study, other research suggests that stigmatising attitudes (McCallum *et al.*, 2016; Velez *et al.*, 2017), and staff despondence (Iqbal *et al.*, 2015; Miller *et al.*, 2001) might reinforce the belief that change is not possible.

While some of these factors are difficult to address in a hospital setting (e.g. a person's home environment), several are amenable to change with appropriate intervention, e.g. levels of self-efficacy, attributions of hospital attendance to alcohol (Rollnick, Heather and Bell, 1992; Wakeman *et al.*, 2017). Moreover, strategies can be employed to increase the effectiveness of delivered interventions, such as visiting patients later during their hospital stay, or delivering multiple brief alcohol interventions, as reported by other researchers (Baumann *et al.*, 2017; Cobain *et al.*, 2011; Mdege *et al.*, 2013). Individuals with complex social and psychological needs may benefit from ongoing support which utilises case management or assertive outreach approaches (Drummond *et al.*, 2016b; Gilburt, Drummond and Sinclair, 2015; Hughes *et al.*, 2013; Parkman *et al.*, 2017b), although gaps in service provision may limit their impact (Fincham-Campbell *et al.*, 2017).

It is also helpful to situate the individual narratives of hospital having limited effect on thoughts about drinking, within the context of the wider cohort study. Quantitative analysis demonstrated significant positive changes across all measured variables from baseline to follow-up (the only exception was SOCRATES 'problem perception' scores). Although there was individual variation, collectively participants made considerable change. Even individuals with an unfavourable drinking outcome at follow-up (i.e. ≥1 heavy drinking day) significantly reduced their median weekly unit intake (120 vs. 85; Z = -3.36, p=.001), AUD severity (AUDIT scores: 32.5 vs. 28; Z = -3.83, p<.001), and psychological dependence (LDQ scores: 28 vs. 23; Z = -3.57, p<.001), throughout the 6-month follow-up period (although whether these reductions are *clinically* meaningful is open to debate). Furthermore, data presented in Chapter 7 suggest that individuals are "bricoleurs" (Pickersgill, Cunningham-Burley and Martin, 2011) who continually re-appraise their relationship with alcohol; this included participants who had experienced numerous alcohol-related hospital admissions. Donna, for example, said:

> *"Every one of those [hospital] stays, 30 or 40 of them, I have got to have learnt something. I have said all along, you know, I spent all that time laying in that hospital bed thinking and thinking and thinking and going over things. So yes, something has got to have sunk in, thank god, something has changed."*

Donna arrived at interview 5-months abstinent, her longest alcohol-free period since childhood. Personal stories like these suggest that accumulation of lessons learned during multiple hospital attendances, or a qualitatively different experience when there, e.g. worsening health, more intensive medical intervention (Stewart and Connors, 2007), can trigger a disruption to a person's biography and be the catalyst for change (Kearney and O'sullivan, 2003; Orford *et al.*, 2006b). Moreover, reports that participants assigned to control groups in hospital-based randomised

controlled trials (RCTs) also reduce their drinking across the study period, support hospital attendance as a "learnable moment" for health-related behaviour change (Kypri *et al.*, 2007; McQueen *et al.*, 2011). The particular significance of hospital attendance is strengthened by the finding that rates of change in drinking for control-group participants are greater for hospital RCTs than those conducted in primary-care (Bischof *et al.*, 2012).

While it is possible that involvement in a research study, even observational in nature, heightened awareness of drinking as a problem and played a role in the observed outcomes (Kypri *et al.*, 2007; McCambridge and Kypri, 2011), my findings suggest that change can occur even for non-treatment-seeking patients with high levels of dependence. Furthermore, as baseline levels of readiness to change were found not to be a predictor of alcohol-related outcomes at six months (Chapter 6), lack of overt motivation should not be considered a proxy for inability to change. As Bradley comments:

> "Clinicians must be taught that ambivalence is the norm, and that momentary statements by patients that they have no interest in considering changing their drinking do not imply there is no benefit of brief discussions about unhealthy alcohol use." (In: Glass *et al.*, 2017, p.6)

To conclude, this chapter provides insight into some of the mechanisms of change observed in participants during the six-month period following hospital attendance. Qualitative data triangulate some of the quantitative findings presented in Chapter 6, as well as illuminating new insights which help to explain some of the differences seen in participant trajectories. Internalising hospital attendance as a biographically disruptive event appeared important for its continued impact on participants' relationship with alcohol; more work is needed to understand how to best facilitate meaningful integration of individuals' hospital experience (or any other potential 'turning point' event) into one's biography to support ongoing change.

Chapter 9 QUALITATIVE RESULTS 3: UNDERSTANDING RECOVERY

9.1 Introduction

This chapter explores participants' views and experience of recovery, and concludes the narrative explicating the theoretical framework presented at the start of Chapter 7. Analysis identified three key categories which are displayed in Figure 12, and addressed in turn:

1) **Recovery identities: ostriches and camels**
- Recovered: "A line in the sand"
- "Always recovering"

2) **Still suffering**
- Feeling lonely
- Identity void and identity distress
- "No reprieve"

3) **Recovery as 'posttraumatic growth'**
- "Biographical illumination"
- Positive by-products
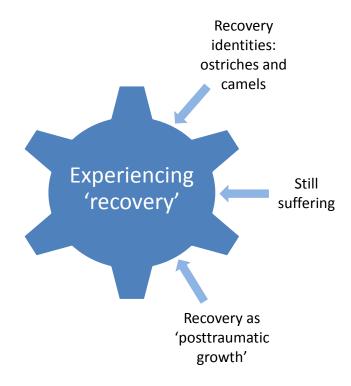
Figure 12:   Experiencing 'recovery'

9.2   Recovery identities: ostriches and camels

Analysis of participant narratives highlighted two main conceptualisations of 'recovery': a state of accomplishment (i.e. "I am recovered"), or an ongoing process (i.e. "I am recovering" or "I am in recovery"). These perspectives appeared to be influenced by beliefs about the nature of problematic drinking (Chapter 7) and other experiences (e.g. hospital attendance, Chapter 8). Data presented here also support other work which recognises that recovery philosophies play an important role in shaping identity processes and coping strategies that underpin change (Best *et al.*, 2017a; Doukas and Cullen, 2009).

9.2.1   Recovered: "A line in the sand"

Several individuals referred to their drinking as a problem of the past (*"It's history, past tense",* Lynn; *"A line in the sand",* Glen), and described recovery as a life event they had "mastered" (Doukas and Cullen, 2009). Moreover, some participants contended that if one relapses back to heavy drinking, but then manages to re-address their alcohol use, they would again be 'recovered'. Clive suggested that the ability to "get over" separate episodes of alcohol dependence is analogous to how *"one gets better from a common cold…once the cold is gone, it's gone; if it comes back, you get rid of it again".* This categorical perception (i.e. one is either

'recovered', or not), challenges the view of recovery as an ongoing process, and research which assumes the stability of an individuals' recovery is dependent upon length of abstinence, e.g. (Belleau *et al.*, 2007; Kougiali, 2015; Laudet, 2007).

Those who viewed recovery as a time-limited process tended to have endorsed the view that their drinking was a 'choice' and/or response to life stressors, rather than a symptom of disease or chronic illness (Section 7.4.2 in Chapter 7). They also reported some of the shortest drinking histories among participants, with experience of low-moderate (rather than high) levels of psychological dependence, and commonly had little (or no) prior treatment experience. Many also described their hospital admission as a 'biographical disruption' (Bury, 1982; see discussion in Chapter 8), that presented the opportunity to 'recover':

> *"If you think of recovery in a normal situation, an everyday life situation, you think of a recovery truck coming to fix your car – it's a short-term thing. Pick it up when it's broken, take it to the garage, in the body's case it's a hospital, fix it, put it back on the road and off you go."* (Joe)

Others agreed that restoration of physical health contributed to the belief that one had 'recovered' (although note that some participants experienced increased vulnerability to relapse when their memory of ill-health faded, Section 8.3.1 in Chapter 8):

> *"Erm, in the short to medium term, I suppose [recovery] means something because of the physiological aspect of it. You can get rid of the alcohol from your system in a number of hours and days, and that's being in recovery…there's bound to be recovery in the vascular system, liver, heart. So, it's a physical recovery more than anything else, not a mental or emotional thing that lasts forever."* (Clive)

While the majority rejected an 'alcoholic' identity altogether, the remainder described a process of "disidentification" or "de-labelling" (Howard, 2006) to mark the end of their problematic relationship with alcohol. For example:

> ***"Interviewer: Some people I have spoken to said they will always be an 'alcoholic' even if they have stopped drinking.***
>
> *Lynn: Oh no, I don't get that. That was just something I might, might have been back then, but it doesn't mean that stays with me forever. It's like with my cancer, I had cancer then, I'm not cancerous now. I may have been 'alcoholic', or whatever, then, but not now."*

Like Lynn, several other participants reported that their research interview was the only occasion they had spoken about their relationship with alcohol since leaving hospital; many had not

engaged in any form of treatment or even discussed the situation with family or friends. Lynn described herself as an *"ostrich":*

> *"I put my head in the sand…I don't want to talk about it or think about it all the time. What's the point of just going on about alcohol when I have stopped and it's not in my life anymore? I never needed [alcohol treatment] and I would never take up the drink again."*

While some evidence suggests avoidance and distraction coping strategies are unconducive for maintaining abstinence (Moos *et al.*, 1990; Moos and Moos, 2006), Levin et al. (2007) found that cognitive avoidance was only detrimental for individuals with low self-efficacy. Moreover, other researchers have found that avoidance of 'addict/recovery' identities is common in those who overcome their addictions without formal treatment (Cloud and Granfield, 1994; Granfield and Cloud, 1996). Thus, for participants like Lynn, who described high levels of confidence to maintain abstinence without external support, *"burying their head in the sand"* might be considered a viable coping strategy.

Further analysis of participant narratives indicated that a possible benefit of considering oneself 'recovered' was to maintain or establish a positive view of self. Identity researchers have found that individuals often evaluate their present selves more favourably than their past selves, e.g. (Wilson and Ross, 2001); by confining their problematic relationship with alcohol to the past, participants could separate their present self from historical alcohol-related behaviours and traits they felt were shameful (*"I don't want to be carrying that baggage around with me; my shoulders aren't big enough to carry that weight",* Graham). Accordingly, several participants asserted they were a *"totally different person"* (Lily) now they were abstinent or successfully moderating their alcohol intake (see Section 9.4 below for further discussion of 'personal growth' following addiction). This accords with the findings of other research into identity transformation in recovery, discussed in earlier chapters.

For those who decided to continue to drink, noticing a difference in their reasons for consuming alcohol was also described as evidence of change (in identity and/or general wellbeing): *"now it's more of a treat than a need. I am using it for a very different reason…I just abused it before, I wasn't having it to relax or enjoy"* (Gillian). Several participants said that alterations in underlying motivations for drinking enabled them to successfully moderate consumption following a problematic relationship with alcohol:

> *"I completely disagree you can never drink again…I now know I can go weeks without it…it's a social thing, and I enjoy a drink. I work my arse off and I am back to normal, my health is incredible. I haven't sat there and said to myself, "you cannot drink" because that's not*

realistic. I don't want to not drink. I like drinking, for good reasons as well. I'm remembering why it was a social thing, and it was fun, and it's just completely different now." (Lorna)

Other participants did not describe identity transformation, but instead discussed the stability of positive personal values and identities that remained intact despite having a problematic relationship with alcohol. For example:

"I don't think my values have changed but I feel in a better position to maintain them if you like, in so much as, my house is scruffy, the hoovering needs doing, the windows need doing, the sides need dusting…I always knew they needed doing and so I suppose you can say the values were always there." (Graham)

Campbell's (1990) research supports the benefit of having a clearly defined, temporally stable self-concept for psychological well-being and self-esteem. In my study, some participants appeared able to maintain a high degree of "self-concept clarity" (Campbell, 1990) by conceptualising their problematic drinking as a behaviour (e.g. 'alcoholic' as a descriptive adjective), rather than part of their identity (e.g. 'alcoholic' as an essentialising noun; Brekhus, 2006). Therefore, for these individuals, 'recovery' meant alignment between core personal values and behaviour, and a return to one's "old" self (*"I feel like I am back to 'me'",* Lorna). Many also rejected recovery-related identities, such as "ex-drinker" or "recovering alcoholic", and instead emphasised non-drinking roles and identities:

"[Alcohol] is not part of me. It comes in and out of my life. Me – I am a photographer, that's who I am." (Clive)

High levels of 'recovery capital' (Cloud and Granfield, 2008) appeared to help participants 'move on' from a problematic relationship with alcohol without the need to re-define their self-concept or commit to a life-long recovery. However, compared to studies which describe increases in recovery capital resulting from engagement in new recovery-orientated networks, e.g. (Best *et al.*, 2016; Best *et al.*, 2015; Frings and Albery, 2015; Mawson *et al.*, 2015; Rodriguez and Smith, 2014), these participants relied on pre-existing 'identity resources' (Biernacki, 1986), including social roles within family life and work, and financial/economic stability:

"I wouldn't ever [return to heavy drinking] because of my grandkids and everything…my flat as well, this was my first council place…it's quiet here now, it's nice." (Glen)

"Having the kids to focus on…and being back here with my mum who is tee-total, I am in a safe place." (Lily)

Accounts of individuals with limited 'recovery capital' corroborate its importance for enabling individuals to effectively 'move on' from their problematic relationship with alcohol (e.g. *"It's impossible when you're homeless…the odds are not good",* Milo). Regression analysis also demonstrated that individuals living alone (i.e. reduced social capital) had greater odds of a poorer drinking outcome (Chapter 6). This supports the narratives of participants who cited loneliness as a key reason for ongoing consumption (Section 8.3.1 in Chapter 8), and other research which recognises social factors as important predictors of drinking outcome, e.g. (Dale *et al.*, 2017; McQueen, Ballinger and Howe, 2017) and even alcohol-related mortality (Herttua *et al.*, 2011).

So long as, during periods of heavy drinking, participants did not deviate far from socially accepted bounds of "normality", e.g. maintained ordinary routines, healthy relationships, remained law-abiding, see: (Nettleton, Neale and Pickering, 2013), many appeared able to address their drinking without a substantial transformation of identity. This contrasts with research which suggests that identity change is an essential component of recovery, e.g. (Gibson, Acquah and Robinson, 2004; McIntosh and McKeganey, 2000;2001). Furthermore, rejection of the 'alcoholic' identity, even during periods of heavy drinking, meant participants did not have to redeem themselves from belonging to what they considered a marginalised social group:

> *"My idea of an 'alcoholic'…they are people who sleep rough, as soon as they wake up they have got to have a drink, and they keep drinking, and they will drink all day until they go to sleep…I was never like that, never. I never needed a drink when I woke up, I waited until evening…and I always worked."* (Gillian)

Narratives of participants who successfully *"carried on with normal life"* (James) contrast with views of recovery as a "dynamic process that requires continued activity and vigilance" (Doukas and Cullen, 2009, p.391). Rick, for example, discussed how he continued to socialise at the pub:

> *"I was going into the pub, in fact, the day after I came out of hospital I went into the pub actually and drank lime and soda…I would walk in the pub and buy a round: '4 pints of Fosters, and I will have a lime and soda, 25p'. I just said, 'don't worry about it, just let me do it, it makes me feel normal and included.' Instead of craving alcohol – I didn't detest it, that's not right either – I was non-fussed about it, I couldn't give a monkeys. I could quite happily go in the pub, well I still can, and not bat an eyelid."*

Rick also explained that he deliberately avoided recovery-orientated groups and treatment services because *"sometimes it's better not to talk".* Lorna agreed:

> *"Going in there [community treatment service], being around it, talking about it all the time, it's not good for me. It just makes me want to drink…I have just tried to get on with it."*

Thus, for some participants, being an "ostrich" also meant avoidance of a permanent "recovering addict" identity, so often associated with people who have a history of problematic drugs or alcohol use (Fomiatti, Moore and Fraser, 2017). Recent research not only supports the possibility of recovery as time-limited, but also finds that individuals who consider their addiction a problem of the past (i.e. they are "recovered") have better psychological health and levels of functioning (e.g. rates of volunteering/employment), than those who stated they are "in recovery" (Best *et al.*, 2017a). This appears to contradict other research findings that AA members, whose narratives implied self-stability during abstinence, demonstrated *poorer* psychological adjustment than those whose narratives implied ongoing change (Dunlop and Tracy, 2013). However, failure to align one's experience with the self-change narrative of AA (Weegmann and Piwowoz-Hjort, 2009), may account for some of participants' poor psychological functioning (Hartney *et al.*, 2003; Hewitt, 2007). Indeed, participants in my study who were required to attend 12-step meetings (during residential rehabilitation, for example), spoke of the detrimental consequences of non-alignment between treatment philosophy and personal philosophy:

> *"I hate it. One, for the simple fact that there's a greater being. Two, that a lot of people say they have 'found the greater good'. Well no, you've just realised perhaps you should stop drinking. People get preachy. I have been to quite a few AA meetings, and I had to as part of rehab…I'd come out feeling like shit and wanting to drink because I just didn't find it helpful at all. For me, it's better to carry on with my normal life, not talk about alcohol all day."* (James)

9.2.2 "Always recovering"

In contrast to narratives above, other participants articulated their experience of recovery as an ongoing process:

> *"I'll always be an 'alcoholic', but just a recovering one…You know, to 'recover' is to get back something you have lost, but that is impossible; you can never go back to what you were before you started [drinking]. You'll always be that recovering 'alcoholic'."* (Milo)

While this conceptualisation is commonly associated with the 12-step model (Best *et al.*, 2017a; Doukas and Cullen, 2009), many participants who expressed this view had never attended AA (although several had attended specialist alcohol treatment services). Even some individuals who rejected addiction as a life-long 'disease' or 'illness', accepted the prospect of a life-long recovery

if it meant they were able to sustain abstinence. For example, Howard, who previously asserted that his drinking was a "choice", said: *"I've realised you have to tell yourself you are in recovery permanently, so you don't slip backwards".* This highlights a willingness to try any strategy which may support recovery efforts, even if it meant changing beliefs about the cause or nature of problematic drinking; as a participant in Dingel et al.'s (2017) study commented: "I don't have to know why it snows, I just have to shovel it!" (p.575).

Most participants who viewed recovery as an ongoing process tended to describe extensive drinking histories with numerous episodes of abstinence and relapse, and were more likely to have experience of specialist alcohol treatment. This corroborates my earlier analyses (Section 9.2.1 above; quantitative results in Chapter 6), and other research, e.g. (Cunningham *et al.*, 2000; Cunningham, 1999), that individuals who successfully 'recover' tend to have less severe alcohol problems and treatment histories. Several participants said they had previously considered recovery as a life event they could "master" (Doukas and Cullen, 2009), but through experience of repeated failures to control their drinking, had accepted recovery as a life-long process:

> *"I know now that I'll never be able to control it. That's one of the realisations, you have got to realise that you can't do it. I have tried, it doesn't work for me...I have heard people say they are in control now, whereas they weren't before. And if that works for them, fine and dandy. But in my experience of knowing people with addiction, it doesn't happen very often."* (Nathan)

Participants explained that viewing alcohol as a permanent *"nemesis"* (Luke), and taking *"one day at a time"* (Barbara) reduced their risk of relapse as it protected against complacency. Indeed, participants frequently attributed past relapses to a failure to maintain awareness of the dangers of alcohol:

> *"There's always a chance of relapse, oh yeh, you are only one day away from it, that's all you are, just one day away. One day at a time, that's all we have got. You know, I have seen it, I've heard it...'alcoholics' who haven't drank for years, suddenly find themselves doing exactly the same again...We stop doing what is suggested, we forget...giving up drinking is easy, I can give up drink and drugs 100 times a day if I wanted, but it's staying stopped you know?"* (Milo)

Participants in other studies have also attested to the ongoing possibility of relapse, e.g. (Kougiali *et al.*, 2017; Neale *et al.*, 2015; Timpson *et al.*, 2016), which aligns with the view of addiction as a chronic disease. To manage this, some participants in this study reported employing daily

strategies or rituals to *"keep it in the forefront of their minds that they've got an alcohol problem"* (Daniel). Len, for example, said:

> *"I'd say every morning, 'don't forget you're an alcoholic'…I have camels all around my house, I have a broach of a camel, I have a stuffed toy camel in my car, I have a photo in my wallet. I think to myself, if that camel can go a day without water, I can go a day without a drink."*

Unsurprisingly, many participants who approached recovery in a similar way, agreed with Howard who said: *"to concentrate on giving up, and stay giving up, takes a lot of time".* Here, being 'in recovery' extended beyond the act of giving up alcohol – it meant a permanent change to one's personal identity. Several used the PRISM to illustrate this, for example:

> *"It's just a part of me, a little part of me because it will always be there…I will always an 'alcoholic' because I could just slip, relapse just like that [clicks fingers]. Before when I was sober, I thought alcohol was right out of my life, like there [see Position 1, Figure 13], but that was a stupid thought. I just hadn't accepted it is part of who I am, but I have now. I am pleased I am in that one [see Position 2, Figure 13 on page 206] because I have got control of it; it hasn't got control of me, it's smaller than me…I won't get rid of it altogether, but it will keep getting smaller."* (Luke)
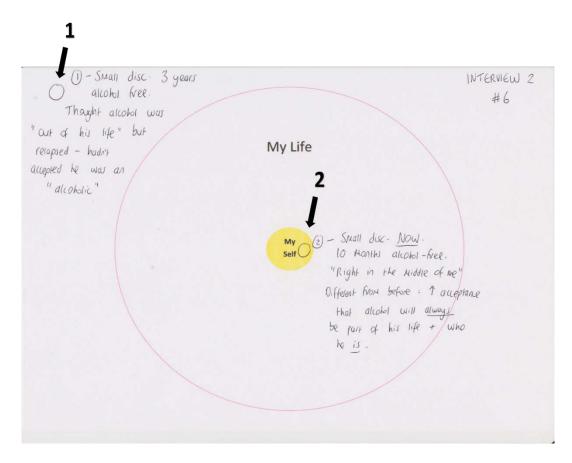
Figure 13:   Scanned (simplified) copy of Luke's PRISM diagram

Integration of recovery into participants' core identity was supported by consistent engagement in 'recovery behaviours' (e.g. *"get a facial once a week"*, Barbara; *"eating properly"*, Daniel, *"go running every day"*, Lee). This mirrors the process described in Chapter 7 (Section 7.3.3) where the routines associated with alcohol dependence became a source of information from which individuals negotiated their 'alcoholic' identity. Marie described the relationship between being sober and her main 'recovery behaviour', knitting:

> *"This is the funny reason why I stopped [drinking]…I used to be here at home, and I was not sober the whole day… and erm, it was my knitting. Of course, when you are drunk you can't knit. I wanted to be sober to be able to do my knitting and that was my goal; to be sober to knit. And then I made myself jumpers and when I wore them, I was reminded of how far I'd come."*

Thus, for these participants, 'recovery' reflected ways of *being*; an ongoing process supported by engagement in activities they had abandoned during periods of dependence. Although "recovery practices" (Hughes, 2007; Nettleton, Neale and Pickering, 2013) were often mundane in nature, they appeared vital in helping participants rebuild a life free from alcohol. Accounts of those who

had not actively participated in 'recovery behaviours' support their benefit for positive identity formation:

> *"I am a dry drunk at the moment…I'm not sober, I don't have the sobriety, the happiness of sobriety. I am just a person that's not drinking…I get no pleasure out of not drinking. I get no pleasure out of anything."* (Len)

My data therefore substantiate claims that recovery often necessitates change beyond a change in drinking behaviour (McQueen, Ballinger and Howe, 2017; Neale *et al.*, 2015; Vigilant, 2008). Some participants said ongoing engagement with mutual aid groups and treatment centres facilitated this process by offering a new routine (*"it gives you that structure…9, 10, 11 o'clock a different activity or group…it keeps you motivated",* Howard). While some participants found the idea of attending therapy or support groups after years of abstinence *"weird"* (Jack) or *"depressing"* (Lynn), others said *"it's just what [they] do"* (Milo). This echoes the findings of Shinebourne and Smith's (2011) interpretative phenomenological analysis (IPA) that ongoing engagement in 'recovery behaviours' can become part of everyday life for those in long-term recovery:

> "Participants' accounts suggest that their involvement with AA activities and processes over a long period evolved into habitual actions which became interwoven into their ordinary daily activities" (p.282).

Social identity models of recovery hypothesise that this process is facilitated through internalisation of group norms and practices which work to consolidate changes in personal identity (Best *et al.,* 2016; Frings and Albery, 2015). Participants described the benefits of group involvement for improving social connection (*"there are people who know the struggles of going through it",* Joe) and self-awareness (*"you go to meetings and realise what you are",* Milo) which support these suppositions, and corroborate the findings of Chapter 4 (*Soberistas*).

9.3   Still suffering

While many participants described beneficial by-products of experiencing and overcoming a problematic relationship with alcohol (see Section 9.4 below), narratives of individuals who were "still suffering" (Vigilant, 2008) cannot be ignored. Experience of ongoing struggles often contributed to the belief that recovery is a never-ending process, although even those who considered themselves 'recovered' described some of the difficulties highlighted below.

9.3.1   Feeling lonely

As reported elsewhere (Nettleton, Neale and Pickering, 2013), participants frequently described an overwhelming desire to "just be normal", particularly in respect to their relationship with alcohol. Participants were acutely aware of the "socially privileged status of normal drinker" (Young, 2011, p.379) and several said they *"live with a lot of resentment"* (Lee) for feeling unable to live up to this ideal:

> *"I would like to be able to go out, have a glass of wine, or go out to dinner and have a drink, but I know one will not suffice. I resent that for me, that is not an option. It's frustrating."* (Barbara)

> *"It pisses me off, I resent it. It really annoys me, it is such a big thing. When you see everyone having fun and know that they won't drink for another week or two without even thinking about it, whereas me, I will get there, have the fun but then I am fighting again."* (Howard)

As both alcohol dependence (Schomerus *et al.*, 2011a; Young, 2011b) and complete abstinence (Bartram, Eliott and Crabb, 2017; Cherrier and Gurrieri, 2013) are considered socially deviant, individuals who give up alcohol to be 'in recovery' are likely subject to a 'double stigma'. Marie said: *"you're damned if you drink too much, but then damned if you don't drink at all – you can't win"*. She described the struggles of being *"a teetotaller"* in a society where drinking is normative:

> *"It was a difficult situation because I was not a drinker anymore and I felt a bit, erm, isolated, I don't know what the word is, a bit different. It was hard, it wasn't easy sitting there not drinking. It made it more difficult to go to occasions where people were having a drink and I was basically the only one there not, you know? It made me feel awkward…uncomfortable."*

Donna agreed that recovery can be *"such a horrible and lonely path, because even being in a room full of people…you are alone."* Other studies have found that individuals often mask their non-drinking status to maintain social connectedness without deviating from group norms (Bartram, Eliott and Crabb, 2017; Pennay, MacLean and Rankin, 2016); for example, they may consume non-alcoholic drinks that resemble alcoholic ones, or volunteer to drive so they are 'excused' for not drinking. Some may avoid alcohol-related situations or peers altogether (Bartram, Eliott and Crabb, 2017; Pennay, MacLean and Rankin, 2016) – a strategy commonly described by participants in my study:

"I try to not go to situations that would permit me to drink. Like staff parties, I very, very rarely go to staff parties…it's crap." (Daniel)

"It's bloody hard, but for me to move on, I have severed my ties from certain people…I've stopped hanging around with the town drinkers. I keep myself to myself." (Jack)

In addition to consciously withdrawing from social situations, many participants said they *"don't get invited anywhere anymore"* (Lee) because of the breakdown in relationships caused by their problematic use of alcohol. Although many participants reported an acceptance that "being lonely is a big part of recovery" (Neale *et al.,* 2015; p.30), their narratives often exuded a deep sadness (see Box 4 for a memo I wrote following my interview with Luke, for example).

Box 4: memo following qualitative interview with Luke

Luke said he spends most of his time alone at home, and because relationship breakdowns and conflict are huge triggers for him drinking, he has decided to stay single. He has also cut contact with everyone he used to drink with to "keep himself safe". He attends weekly recovery groups but does not allow himself to get close to other people who attend in case they relapse and "bring him down". Although Luke stated he is "happy to be in recovery", I sensed real sadness that for him, being sober meant being lonely.

9.3.2   Identity void and identity distress

Recovery appeared to be a particularly difficult process for individuals whose identity had become enmeshed with alcohol, such that they reported few (or no) self-domains beyond alcohol consumption (Sections 7.3.3 and 7.3.4, Chapter 7). Giving up alcohol left some participants feeling even "emptier" than before, as they lost their primary source of self-meaning:

"I have lost a friend. It might sound crazy to say that, but I have lost a friend in the drink…a friend I was with every day for years; 7 days a week, 52 weeks of the year, for a long time. It was there every day for me and now it's gone." (Nathan)

Here, recovery was described as an existentially painful experience as participants were faced with an "identity void" (Howard, 2008, p.181). Several agreed with Daniel who said he *"felt very lost",* not only in terms of a direction for the future, but in understanding who he is as a person. Erikson (1968) identified a vital developmental stage during adolescence in which individuals consolidate their identity; however, participant narratives corroborate research that early-onset

AUD can interfere with the development of a coherent sense of self (Brown *et al.*, 2008). Lee, for example, said:

> *"I went from a school boy to a soldier who drunk as much as he could whenever he got the chance. Where is the normal person in the middle of that? I don't know who he is, if there even is one. So yeh, I am 45 years of age, and I have just been born really."*

These findings sit within a body of work which finds that individuals with early-onset AUD typically develop more severe drinking problems and display poorer outcomes over time (Brown *et al.*, 2008; Chi *et al.*, 2014). Individuals who develop alcohol problems later in life often already possess greater levels of 'recovery capital' which can be drawn upon to support recovery efforts (Cloud and Granfield, 2008).

In addition to 'identity void', some participants described what I call 'identity distress' as they attempted to make sense of *"the horrible things [they] did"* in the past, and what this meant for who they are in the present:

> *"I loathe myself, the selfishness and the horrible things I have done…alcohol was part of the instigation of that, but I think, is that fucking part of me? Is that what I am, an evil bastard? All these questions come up. Are you just an evil fucking piece of shit?"* (Nathan)

As reported elsewhere (Mackintosh and Knight, 2012; Roper *et al.*, 2013), preserving a tolerable self-image in early recovery appeared to be a considerable challenge for some participants. Moreover, inability to manage such 'identity distress' increased risk of self-destructive behaviours such as further substance use, self-harm, and suicidality (*"Facing life sober…I still get lots of suicidal thoughts, a lot; it's all the shame and the guilt again",* Milo). Here, my data resonate with research which considers experience of addiction as a form of trauma (Haroosh and Freedman, 2017; Hewitt, 2007); accordingly, individuals in early recovery may benefit from treatments focusing on establishing safety and breaking destructive cognitive-behavioural cycles that perpetuate pain (Najavits, 2002).

9.3.3 "No reprieve"

Some participants described how their relationship with alcohol had claimed so much of their life that they were unable to *"switch off"* from it, even when abstinent. This made it difficult for some individuals to 'move on' from their former alcohol-related self (Section 9.2.1 above), even if they wanted to:

"It annoys me that normal drinkers wouldn't even be having this conversation…you end up analysing things in a way that normal people wouldn't…Now alcohol is a real big part of my life – not drinking it – but the prospect of it, you know, it's something I have to take into consideration whenever and wherever I go." (Daniel)

Others explained their ongoing physical suffering also provided a constant reminder of their problematic relationship with alcohol. For my participants, the "corporeal remnants of years or decades of self-abuse" (Vigilant, 2008, p.289), included experience of whole-body aches and pains, sleep disturbance, ascites, total loss of libido, and gastrointestinal problems including bowel incontinence. Taking daily medications and/or attending regular medical appointments also made it difficult for participants to leave their relationship with alcohol behind: *"I'm going back and forth to the hospital again for appointments because of my drink, so it's always on my mind"* (Luke). This contrasts with the experiences of individuals who described complete restoration of physical health; Graham, for example, said he feels he has been given *"another life".* Cloud and Granfield (2008) recognised poor physical health as a form of 'negative recovery capital' that can undermine recovery efforts; they noted that individuals may have "diminished capacity for feeling good naturally" (p.1979). My participants also explained that a reduction in alcohol intake increased their awareness of unpleasant bodily sensations: *"I must have had these medical problems anyway, but always been covered up – being pissed, you never notice them"* (Howard).

Other participants commented on the challenges of dealing with intense emotions when alcohol is no longer used to *"blot them out":*

"I'm starting to get emotions back…the emotion part is, I think even fucking harder than anything else because where I didn't give a shit about nothing, that has been switched back on again, and I am starting to care about things, starting to care about people again." (Nathan)

Other research has recognised the struggles experienced by people in recovery whilst trying to manage emotional changes, e.g. (Neale *et al.*, 2015; Vigilant, 2008; Witkiewitz and Marlatt, 2004). Neale et al.'s (2015) participants suggest that the challenge is learning to accept negative affective states as part of normal human experience, rather than fighting to prevent them occurring, or denying their existence. Milo agreed: *"the good news is you get your feelings back; the bad news is you get your feelings back".* However, without personal skills to handle intense feelings, or access to appropriate support, participants said they *"could be in trouble"* (Milo). Rick's experience corroborates this; he said that when he first stopped drinking he became *"depressed, down, miserable, grumpy, very angry",* and *"when you start to feel bad about yourself, the easy solution is to drink".*

In addition to internal/personal barriers to establishing a new alcohol-free identity, some participants felt hindered by friends and family who were less able or willing to forget the past:

> *"Howard: Do you know the worst thing, and I swear it's the worst thing in the world? It's when you don't drink, there's no problem with it – having a coca cola, no problem – until somebody goes, 'oh I'm sorry, we shouldn't have been drinking around you'.*
>
> ***Interviewer: Why is that so difficult?***
>
> *Howard: Because it upsets me that it's affecting them, and it draws attention to the fact that I've had a problem with alcohol – there's no reprieve."*

This provides another reminder that recovery seldom remains at the level of the individual, and the benefit of engaging with others who support an 'alcohol-free identity'. Acceptance and understanding of abstinence may explain why some individuals find solace in attending recovery/treatment services with likeminded others. However, several participants expressed "resentment" at feeling the need to attend treatment services or recovery groups to maintain abstinence, for example:

> *"It does get me down that I am constantly obsessing over alcohol and my recovery, and I will always need to be getting help for it; it's never going away – that pisses me off sometimes."* (Lee)

Some authors have argued that engagement with (and ongoing monitoring by) treatment services, can perpetuate a view of self as "disordered…pathologically prone to relapse'' (Savic and Fomiatti, 2016, p.183); this in turn, may reinforce perception of the need for continued treatment. While my quantitative findings (Chapter 6) highlighted a significant association between treatment engagement and level of psychological dependence, further research is needed to understand this relationship. This is an important endeavour as psychological dependence is often associated with psychological distress (Fairhurst *et al.,* 2014; Chapter 7); treatment discourses which require individuals to reify their experience as a life-long disorder of compulsion might therefore undermine efforts to make positive change (Barnett *et al.,* 2018; Reinarman, 2005; Savic *et al.,* 2017; Savic and Fomiatti, 2016). Indeed, several authors have noted that a significant part of the recovery process takes place outside of treatment or healthcare settings, e.g. (Hughes, 2007; Nettleton, Neale and Pickering, 2011; Skogens, von Greiff and Topor, 2018). My findings therefore corroborate the view that individuals might benefit from increased support to cultivate wider personal and social environments that are conducive for sustained change (Borg and Davidson, 2008; Davidson and White, 2007).

9.4 Recovery as 'posttraumatic growth'

Despite the struggles discussed above, participants highlighted a range of "positive by-products" (McMillen *et al.*, 2001) of experiencing and overcoming a problematic relationship with alcohol. Just as experience of traumatic, stressful, or life-changing events may be antecedents to personal growth (Tedeschi and Calhoun, 2004), my data support emerging evidence that recovery from addiction can serve a similar function (Haroosh and Freedman, 2017; Hewitt, 2007). Even those who considered themselves 'recovered' and denied any identity transformation, recognised some positive consequences of their negative experiences. Tedeschi and Calhoun (2004) coined the term "posttraumatic growth" to describe the kind of personal development that can sometimes follow adversity.

The findings presented in this section substantiate patient-centred perspectives of recovery which acknowledge the benefit of personal growth and positive change that extend beyond achieving abstinence (Laudet, 2007).

9.4.1 'Biographical illumination'

Some participants felt that acceptance of a life-long 'recovering alcoholic' identity was necessary for their sobriety; others adamantly disagreed (see Section 9.2 above). Either way, every participant inadvertently described a process of identity negotiation which accounted for their prior experiences of alcohol dependence, treatment, hospital admission(s), and even research participation (Lakeman *et al.*, 2013). Whether participants discussed identity transformation or identity stability through their experience and/or recovery from a problematic relationship with alcohol, both appeared to result in a more clearly defined, illuminated sense of self. As Barbara commented: *"Everyone is constantly changing and learning. We are all shaped by our experiences; they make us who we are."*

While some authors argue that individuals need a 'foundational' period of abstinence before they can experience personal growth (e.g. Laudet, 2007), many participants in my study described positive identity development even during active addiction. Recall Donna's experience of multiple alcohol-related hospital admissions described in Chapter 8, for example:

> *"Every one of those [hospital] stays, 30 or 40 of them, I have got to have learnt something…something has got to have sunk in, thank god, something has changed."*

I therefore echo Neale et al.'s (2011) encouragement for individuals to work on their identity project(s) before reducing or abstaining from alcohol, as this is likely to benefit subsequent recovery efforts.

For individuals who felt that acceptance of a life-long 'recovering alcoholic' identity was necessary for their sobriety, episodes of relapse were often described as integral to the learning process; this corroborates Kougiali and colleagues' (2017) perspective of recovery as a discontinuous and non-linear journey of ongoing personal discovery. When I asked Milo, for example, how he managed to accept himself as an 'alcoholic', he said:

> *"Going through a lot of pain, a lot of research, a lot of slip ups, a lot of finding your own way around it all…I never, ever stop learning about myself. When I relapsed last year, I lost my clean time, but I didn't lose my knowledge."*

These narratives resonate with Tan's (2018) concept of "biographical illumination", developed through her work with individuals with autism. She found that rather than disrupting biography (Bury, 1982), acceptance of an autism spectrum disorder diagnosis resulted in a more valued self-concept that enhanced personal biography beyond medical meaning. Equally, for participants in my study, their 'recovering'/'recovered' self generally transcended diagnostic labels and medical conceptualisations of 'alcoholism' (Robinson, 2016); it provided a framework from which to negotiate and manage their personal and social identity. Even those who rejected or shed alcohol-related identity labels (Howard, 2006), were guided by their conceptualisation of self, as shaped by their relationship with alcohol:

> *"'Alcoholic', it's just used as a nasty word. It's actually just an insult…I don't even really like the term 'alcohol abuse' – I'm not abusing the alcohol, it's abusing me. I want to raise awareness that it's something so much deeper than some people can ever imagine."* (Lorna)

Like Tan's (2018) participants, those in my study often found solace in connecting with others who shared similar experiences of alcohol dependence (Moos, 2008). For those engaging in recovery groups or other alcohol treatment, similar identity processes were identified as described earlier in Chapter 4 (interviews with *Soberistas* members/browsers) and will therefore not be reiterated in full. For example, participants acknowledged the benefits of connecting with likeminded others for reassurance (*"I realised I'm not alone",* Barbara), companionship (*"the company and the laugh",* Graham), and understanding self (*"going to meetings and realising what you are",* Milo). For those not engaged in recovery groups or treatment programmes, research participation provided an opportunity to explore, and sometimes validate, thoughts about self (Lakeman et al., 2013):

"My conversation with you Sophia, and all the things I have told you, they are all floating around in my head...I just spent an hour talking to you and I have bared my soul, my 'alcoholic' soul to you…Talking to you makes me think. If nobody's talking to me, I'm not thinking about it, right?" (Trevor)

Social support and interaction was also found to help some participants make sense of biographically disruptive events, such as hospital attendance, that shape ongoing views of alcohol and self. Steve, for example, said he attended community treatment services for the first time following his hospital admission 'to get answers': *"I was unwell. I had just come out of hospital and I wanted answers…Why has this happened to me? Why did I get ill? Why am I like this?"*

These accounts align with symbolic interactionist views of identity in which individuals understand themselves through their interactions with others (e.g. Goffman, 1959). As Scott (2015) argues, identities are "created, shaped, maintained, communicated, presented, negotiated, challenged, reproduced, reinvented, and narrated" (p.11); evidence of this dynamic process is supported by my data of how individuals constructed their own version of a 'recovery' identity.

9.4.2   Positive by-products

Participants highlighted various other areas of growth having experienced and overcome a problematic relationship with alcohol. Many of my findings mirror those reported by McMillen and colleagues (2001) who conducted focus groups with individuals in recovery to assess positive by-products of chemical dependence. For example, my participants also reported increased self-efficacy and coping (*"I'm in a stronger place now to cope",* Luke), closeness to family and friends (*"I realised just how much my husband does care; we're stronger than ever now",* Gillian), compassion toward others (*"If somebody was clearly having the sort of problem that I was having, I would really very much want to help",* Clive), and an appreciation for the 'simpler things' in life (*"Just getting up in the mornings and going for a walk. Just the freedom to do that. I couldn't do that two years ago, I'd have to get down a few drinks first",* Nathan).

Furthermore, having been in hospital, many participants agreed with Gillian who said she has *"more respect for alcohol having seen the effect it can have on [her] body".* This often prompted participants to take greater care of their physical health (*"I went back to gym…people are saying it now, I am looking so much healthier",* Lily), which in turn improved psychological wellbeing (*"You start going to the gym, you start training…healthy body, healthy mind; the two coincide with each other",* Nathan). Recovery from more serious alcohol-related ill-health also provided some participants with greater life meaning and purpose; a finding reported in other studies of

posttraumatic growth following physical injury or illness (Hefferon, Grealy and Mutrie, 2009; Kampman *et al.*, 2015). Lee, for example, said:

> *"I have been kept alive through all of this, through 20+ years of being a soldier, through 40 something blue-light visits to hospital, 3 assessments in a mental institution, 3 suicide attempts, 4 resuscitations, 1 cardiac arrest, and I am still walking, I am a miracle. So, something has kept me alive through all of that, somebody. And so, there's a reason for it. I don't know what that reason is, I want to find out."* (Lee)

It is important to note, however, that despite discussion of personal growth, not all participants considered it a by-product of 'trauma'. This included participants who also reported serious ill-health, numerous hospital admissions, relationship breakdowns, and other 'traumatic' experiences within the context of alcohol dependence. Narratives of individuals, like Daniel, therefore provide an alternative perspective on growth following addiction:

> *"I am quite happy where I am because I think I'm a lot nicer person, I think I'm a lot more understanding and worldly, so I don't, I wouldn't change the last sort of like 10, 15 years of my life necessarily. The one reason I wouldn't change is because of the experiences and the people I've met…When I am old and grey and I've got my grandchildren sat on my knee and I can tell them all my stories – is all I wanted to be was that bank manager that just went to work, 2.4 kids, come home, didn't really love his wife but put up with her for the last 40 years, and just lived a plain life? I want to change it now, but I wouldn't have wanted to change it then to lose all my experiences."*

While existing studies of 'posttraumatic growth' in addiction have recruited participants from recovery groups (Dunlop and Tracy, 2013; Haroosh and Freedman, 2017) or specialist treatment centres (McMillen *et al.,* 2001), many participants in my study had little or no specialist treatment experience. Indeed, it is possible that some of the 'personal' posttraumatic growth effects reported in other studies, and by some of my participants, may simply reflect treatment exposure or recovery group narratives (Fomiatti et al., 2017; Hartney et al., 2003; Hewitt, 2007).

9.5   Summary

The findings presented in this chapter extend and refine a literature which has often assumed a homogeneity of recovery experiences and recovery philosophies. Apart from a few isolated studies, there is limited recognition that approaches to recovery can differ both between, e.g. (Best *et al.*, 2017a; Neale *et al.*, 2015; Pienaar and Dilkes-Frayne, 2017; Witbrodt, Kaskutas and Grella, 2015) and within, e.g. (Christensen and Elmeland, 2015; Howard, 2006) individuals.

Participant narratives were often laced with confusion and contradiction, and highlighted both positive and negative aspects of recovery. Even the terminology used to describe recovery varied substantially. This contrasts with studies which recruit participants through one community, such as *Soberistas*, 12-step groups or therapeutic recovery centres; even Kougiali et al., (2017), whose study highlighted recovery as a complex and discontinuous process noted a "uniformity in the structure of the narratives" (p.12) because many participants accessed the same treatment services. The present study therefore provides an extended insight into how a diverse cohort of individuals described and interpreted the resolution of a problematic relationship with alcohol.

Participants themselves frequently emphasised the individuality inherent in experiencing and addressing a problematic relationship with alcohol. Only a minority explicitly stated that recovery was only possible through engagement with one type of support. Far more common was the recognition that "what works" for an individual will change over time, particularly for those with more extensive drinking and/or treatment histories. Analysis highlighted that individuals often draw upon a range of strategies, experiences, and pieces of advice to facilitate/maintain change; Donna described this process of selecting the most useful sources of information and support as a *"pick n' mix"*. Participants who had accessed treatment in the past often described beneficial elements alongside aspects they did not find helpful, supporting the notion that people 'cherry-pick' according to their wants and needs *at the time*. For example, Howard said that while he finds AA's mantra of *"one day at a time"* helpful to prevent feeling overwhelmed by the prospect of life-long sobriety, he *"doesn't like the whole higher power thing…it's a bit too airy fairy, and I don't want to talk only about alcohol";* he has since started to engage with a community treatment service which provides access to a range of non-alcohol-related activities (e.g. cooking, painting, gardening).

Unlike Donna, many participants did not describe the "pick n' mix" process as a conscious one; it was only through further analysis of interview scripts that evidence of this process happening became apparent. In fact, when asked how they managed to reduce/stop their drinking, some participants could not provide an answer at all, claiming it "just happened". Furthermore, several participants seemed to have arrived at a stage in their 'recovery' where they had either exhausted treatment options or gained everything they could from them and decided to *"do it on [their] own"* (Jack). This resonates with some participants in the *Soberistas* study who decided to leave the website because they had *"taken everything out…and put as much back in as [they] could"* (Section 4.7.3 in Chapter 4). Moreover, some participants were sceptical (even resentful) of attending treatment services and recovery groups on an ongoing basis, as they were sometimes felt to perpetuate the problem by keeping alcohol at the centre of one's life; that baseline treatment engagement was associated with 6.3 times reduced odds of making clinically significant

change in psychological dependence (Section 6.5.2.2 in Chapter 6) triangulates this finding, and warrants further investigation. This is especially important considering the relationship found between psychological dependence and psychological distress (Appendix R). It is crucial that interventions/services designed to support individuals do not undermine positive changes in beliefs (e.g. self-efficacy), behaviour, quality of life and emotional wellbeing, by inadvertently reinforcing a state of dependence, as discussed elsewhere (Barnett *et al.*, 2018; Dwyer and Fraser, 2016; Reinarman, 2005; Savic *et al.*, 2017; Savic and Fomiatti, 2016).

Another key finding is that many participants were willing and able to adjust not only their coping strategies, but also their epistemological and ontological beliefs about addiction and recovery. Adjustments were sometimes initiated by learning of new evidence or viewpoints (e.g. hearing for the first time that addiction might be conceptualised as a 'disease'), or recognition that a certain perspective was more conducive for sustained change (e.g. conceptualising recovery as a life-long process to protect against complacency/relapse). Findings in this study suggest that beliefs and experiences of recovery are shaped by innumerable factors including demographic variables (e.g. age, living situation), treatment exposure, personal/social discourses, and experience of 'biographically disruptive' events. As such, individuals' ideas about 'recovery' appear to be fluid and amenable to change (corroborating the findings reported in Chapter 7 regarding drinking identity fluidity). A single ideological approach to treatment and support for people with AUD is therefore likely to be futile; a system allowing individuals the flexibility to change and grow, as their experience of addiction and recovery does, is essential. Failure to do so can result in disempowerment and treatment avoidance or drop-out (Klingemann, 2011; Savic *et al.*, 2016; Savic *et al.*, 2017; Savic and Lubman, 2018). Just as some argue that we should allow individuals the freedom to define and label their 'recovery' as they wish (Doukas and Cullen, 2009), the analysis in this study goes further to suggest this include the freedom for people to change their view (e.g. "de-label" from 'alcoholic' to 'ex-alcoholic' (Howard, 2006); or reject a label together) without accusing them of being 'in denial'.

This analysis also supports others' contributions which suggest this freedom is made difficult by entrenched social, political and treatment discourses about the nature of addiction and recovery (Barnett *et al.*, 2018; 2017; Fomiatti, Moore and Fraser, 2017; Fraser, 2016; Fraser *et al.*, 2017; Khadjesari *et al.*, 2018; Klingemann, 2011; Savic *et al.*, 2017). Conceptualisations of recovery from the perspectives of those with a range of lived experience[12] should be considered viable

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[12] For example, Clive's proposal that experience of problematic drinking is analogous to the common cold (see Section 9.2.1 earlier).

alternatives for framing a problem often viewed as an "irreversible rigidity of essence" (Fraser, 2016, p.12). Furthermore, examples of participants who said they were successfully moderating their alcohol consumption (as opposed to abstaining) contribute to widening the "boundaries of thinking" in the alcohol treatment field (Storbjörk, 2017; van Amsterdam and van den Brink, 2013) – and examples of those doing so without access to any specialist treatment widen them further (Witkiewitz, Dearing and Maisto, 2014). Indeed, many of my participants did not want to engage in specialist support services, a finding reported by another recent hospital-based study of harmful/dependent drinkers (Parkman *et al.,* 2017b).

However, there is a fine balance between supporting individuals in moving beyond a life defined by addiction and engagement in specialist treatment (as advocated by an initial UK government drug strategy policy in 2010, (HM Government, 2010), and failing to offer ongoing intervention if wanted/needed. With incentives for providers to demonstrate successful treatment completions (Day, 2018; Jones *et al.*, 2018), individuals can be shunted out of treatment services soon after their substance use has stabilised (Best, De Alwis and Burdett, 2017b). Equally, one participant in my study found that because he had achieved abstinence by the time he was given an appointment at community alcohol services, *"they didn't really want to know"* (Rick); unsurprisingly, he did not return. Ironically, these realities of poor treatment provision/experience (Alcohol Concern and Alcohol Research UK, 2018) exist alongside discourses which enact individuals as "fragile subjects in need of professional help" (Savic *et al.,* 2016, p.576).

The findings of this study also highlight that participants often dealt with "multiple recoveries" (Vigilant, 2008) which extended beyond addressing their problematic relationship with alcohol; they described a need to recover from physical illness, psychological distress, identity conflicts, and damage to social networks, for example. Indeed, many reported ongoing suffering even after successfully changing their drinking behaviour. More recent government and third-sector reports have recognised the need to offer ongoing provision for individuals in recovery, particularly those with chaotic patterns of behaviour and physical and mental health comorbidities, e.g. (Public Health England, 2018b; Ward, Holmes and Booker, 2015), although services are currently ill-equipped to provide such support (Alcohol Concern and Alcohol Research UK, 2018). They also note the importance of supporting individuals with AUD during and after a hospital stay. My results and those from other groups, e.g. (Clark *et al.*, 2017; Lid *et al.*, 2012; Mdege *et al.*, 2013; Simioni, Cottencin and Rolland, 2015), suggest many harmful/dependent drinkers attending hospital would welcome and benefit from ongoing support after discharge. However, there are few examples of services offering support that falls between simple brief interventions and specialist treatment services (Haringey Advisory Group on Alcohol, 2011; Heather, 2011). Moreover, the demand for such support is likely to increase as more risky drinkers are identified

in hospital following the launch of the CQUIN in April 2018, which incentivises identification and the delivery of brief advice (IBA) across hospitals (NHS England, 2016).

There needs to be development of alternative treatment options, of varying intensities, to mirror the diversity of individual experience and need (Cunningham and McCambridge, 2011). This could ease the burden on already stretched specialist treatment services (Alcohol Concern and Alcohol Research UK, 2018), and encourage a greater number of individuals to seek help. The emergence of online networks, such as *Soberistas,* is encouraging in this respect, but more empirical work is needed to understand their effectiveness and potential reach. There may also be a role for 'social prescribing', a model currently used in UK general practice, within the context of addiction treatment, to support individuals holistically by building interests beyond alcohol use and recovery. The idea is to link patients with services in the wider community that offer befriending, activities including sport and craft, and volunteering opportunities, to improve health and wellbeing (University of Westminster, 2016). However, more work is needed to assess the model's effectiveness in primary care (Bickerdike *et al.*, 2017) and I am not aware of any reports about its use within the addictions.

Interventions developed through co-produced efforts between individuals with lived experience, clinicians, and researchers also have exciting potential, but again, examples of such work are limited. Pienaar and colleagues (2017) describe the development of an online resource (www.livesofsubstance.org) to disseminate diverse and nuanced accounts of addiction to the public, policy makers and treatment providers. Using data collected via qualitative interviews with individuals with lived experience, the authors hope the project will contribute to "eroding addiction stigma" by "presenting people who use drugs as complex individuals, with rich, varied experiences whose lives cannot be reduced to the typical addiction narrative of ruin and redemption" (Treloar *et al.*, 2017, p.6). Data presented in the previous three chapters support the need for further innovations such as this.

A final finding worth considering is that many participants described beneficial 'by-products' of having experienced a difficult relationship with alcohol. Although, more work is needed to understand the 'posttraumatic growth' concept (Tedeschi and Calhoun, 2004) as applied to addiction recovery, as this area of research is in its infancy. A focus on positive self-change is commonplace in grassroots recovery movements (Krentzman, 2013) and often emphasised in peer-led groups (e.g. *Soberistas*) or self-help therapies. For example, in their self-help guide to overcoming addictions, Cloud and Granfield (2001) urge readers to recognise the gains to be had from the suffering associated with addiction. They say: "you have been forced to self-reflect and to make changes…in a way, your crisis is actually an opportunity that others never have" (p.219).

Further investigation is needed to assess the feasibility and acceptability of incorporating a framework of positive psychology within and across the care system (including primary, secondary, and tertiary levels) to possibly benefit those who do not access such resources.

Chapter 10   OVERALL DISCUSSION

10.1   Introduction

This chapter provides a summary of the main findings from the studies described within this thesis and explores how they address the overarching research aims, making an original contribution to knowledge. A final theoretical model is presented which aims to synthesise the various arms of data described in earlier chapters. I also acknowledge the strengths and limitations of my research, after which the implications for future research and clinical practice are discussed.

10.2   Summary of research aims and study findings

As discussed in Chapter 1, clinical addiction research has disproportionately focused on patients with severe dependence in specialist (particularly 12-step) settings, which may have narrowed our understanding about the nature of problematic alcohol use and recovery. Moreover, research studies often impose strict inclusion criteria, resulting in the recruitment of participants who are not typical of patients seen in clinical practice. The overarching aims of this thesis therefore, were to: 1) gain an in-depth understanding of how those with a range of drinking patterns and treatment experiences, whose perspectives are currently underrepresented in the literature, conceptualise their relationship with alcohol, and 2) generate theory about processes and determinants of recovery.

An initial exploratory qualitative study with individuals engaging with *Soberistas*, a new (and previously unresearched) online mutual aid group, highlighted the role of identity processes in addiction and recovery. Analysis suggested that participants benefited from the freedom an online group affords, to choose how they defined their problematic drinking and recovery, and incorporated it into their overall sense of self. Many described maintaining "normal" selves offline, which often concealed their hidden struggles with alcohol; *Soberistas* granted users the control over how they presented themselves, and the pace at which they engaged with the site to address their 'destructive' alcohol-related identity. These findings formed the basis of the theoretical framework (Page 54), which suggests that through the management of multiple facets of self, and engagement with *Soberistas* in various stages, participants could embark on a path to recovery.

The alternative conceptualisation of alcohol problems and recovery offered by *Soberistas*, appeared to facilitate participants' decision to contemplate and then action change, especially when more traditional forms of support had proved ineffective or did not appeal. Specifically, *Soberistas* rejects the need to occupy a totalising "alcoholic" identity, and instead promotes personal growth, the development of an "authentic self", and a "sense of freedom" that extends beyond giving up alcohol. Many participants described a new-founded confidence through their identity as a *'Soberista'* which means, as the site's slogan reads, "loving life in control" (Rocca, 2018). Moreover, few participants identified a single "rock bottom" event prior to giving up alcohol; instead they discussed a gradual realisation of alcohol conflicting with other, more favourable identities ("droplets of awareness").

To extend the findings of Study 1, a mixed-methods follow-up cohort study of patients with alcohol use disorders (AUD) attending hospital was then conducted to explore identity and change processes over time, in a more heterogeneous population. Although >80% of participants were not in specialist alcohol treatment at the time of their unscheduled hospital attendance (see Chapter 6), their use of secondary care services and assessment by clinical staff, brought to the fore their problematic alcohol use – and the option of secrecy was removed. This contrasted with the experiences of *Soberistas* participants, many of whom never spoke of their problematic drinking. Quantitative measures of change between baseline (hospital attendance) and follow-up (six months later), were supplemented by exploration of participants' qualitative narratives of change, resulting in the development of a theoretical framework entitled "negotiating alcohol use and self" (Page 141).

Baseline alcohol consumption (measured using the AUDIT-C, covering the previous six months) and treatment engagement at the time of hospital attendance, were strongly associated with outcomes in both heavy drinking and dependence, implying a degree of consistency in behaviour over time. However, a large proportion of the variance in outcomes was left unaccounted for in regression models (Page 129). Qualitative narratives highlighted multiple and intertwined contextual, social, and psychological factors that may have played a role in shaping individual outcomes. Such factors included: participants' perception of the nature and degree of their alcohol consumption and levels of dependence, philosophical assumptions about problematic drinking and recovery, personal/familial experiences, perception of "turning point" events such as unplanned encounters with healthcare professionals, and exposure to various discourses about addiction.

Interestingly, there was no association found between levels of motivation to address drinking in hospital, and outcomes in terms of heavy drinking days and psychological dependence. While

methodological and design factors may have played a role (see Section 6.6 in Chapter 6), this result is somewhat counterintuitive and challenges the usefulness of interventions based on enhancing readiness to change (e.g. motivational enhancement therapy). The concept of "biographical disruption" provided a theoretical lens with which to understand the impact hospital attendance had on participants' sense of self and relationship with alcohol. The ability to meaningfully integrate hospital experience into one's *ongoing* autobiography appeared crucial for participants making sustained changes in their drinking behaviour – and various factors were found to facilitate or hinder this process (see Section 8.5 in Chapter 8 for a summary). My analysis therefore supports the findings reported by Orford and colleagues (2006a; 2006b), in their grounded theory studies of the change process, that change typically occurs within a complex web of systems that include, but extend beyond, motivational factors.

Participants also described numerous strategies to support their recovery efforts; some likened their approach to that of an "ostrich" by drawing a firm line between their problematic use of the past and their life going forward, while others said they benefitted from constant reminders of their life-long identity as an "alcoholic", whether it be a hospital wristband or toy camels. Importantly, participants played an active role in selecting discourses/approaches that best aligned with their personal philosophy and needs *at the time*, articulated by one participant as a "pick n' mix" process. Thus, the strategies employed were found to vary greatly not only between, but within individuals, over time. Finally, participants spoke of ongoing and multiple recovery journeys that extended beyond reductions in alcohol consumption, including those related to health, psychological wellbeing, and social connection. Thus, while many attested to the benefits of recovery, narratives of suffering were clear; such experiences were found to have a profound impact on how individuals conceptualised their recovery and associated sense of self (e.g. that one is "always recovering"; see Section 9.3).

10.2.1 A theoretical framework of alcohol and recovery self-concept fluidity

In order to synthesise the findings described above, from my research with both *Soberistas* members and browsers, and hospital attendees, an extended and refined theoretical model is presented in Figure 14; this builds upon the model first presented at the start of Chapter 7 (Figure 8).
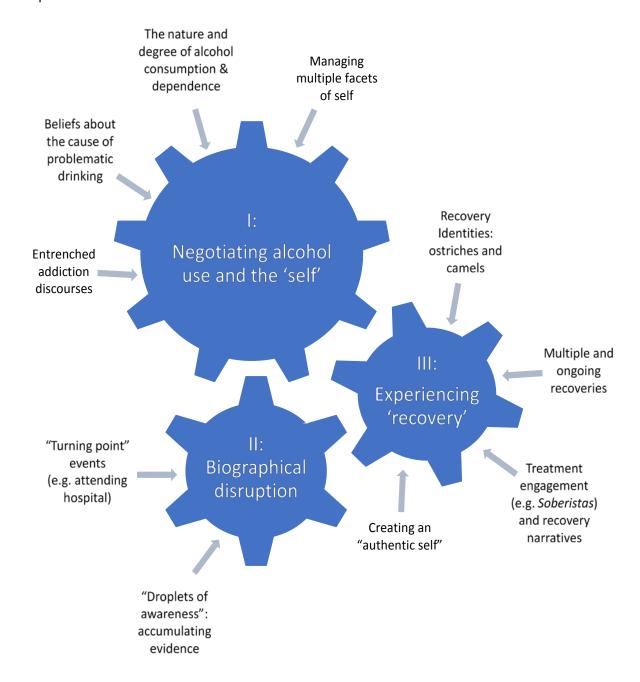
Figure 14:   A theoretical framework of alcohol and recovery self-concept fluidity

The model speaks to the dynamic, fluid, and complex nature of living with, and moving beyond, a problematic relationship with alcohol; a shift in one element of the system causes a shift in the others. For example, increased awareness of accumulating harms of alcohol (Cog II), may challenge entrenched discourses surrounding "alcoholism" (Cog I), and prompt engagement with a recovery group, such as *Soberistas* (Cog III); this group membership in turn shapes view of alcohol and self (Cog I). Similarly, repeated experience of loss of control over one's drinking may challenge one's existing belief that drinking is a "choice" (Cog I), and instead result in the acceptance of abstinence, and recovery as a life-long process that requires constant self-

monitoring (Cog III); this personal surveillance may then affect perceptions of potentially biographically disruptive events, such as hospital attendance (Cog II: *"I knew I was heading for the hangman's rope…it wasn't a wake-up call"*, Len; see Page 191).

This theory of alcohol and recovery self-concept fluidity aligns with social constructivist ontology; what it means to have, and recover from a problematic relationship with alcohol, is dynamically influenced by social interactions and experiences (c.f. Neale, Nettleton and Pickering, 2011). Importantly however, my data highlights that the impact of "turning point" events, or gradual accumulation of evidence of the harms of alcohol use, must be sufficient to disrupt one's ongoing autobiography; as the thresholds at which this occurs appear to vary between individuals, and within individuals over time, similar experiences may not materialise into behaviour change. This model resonates with Kearney and O'Sullivan's (2003) identity shift theory in that it is the individuals' *perception* of events that is important, not the event itself.

Evidence for the continual (re)negotiation of identity in relation to alcohol and recovery was found in various strands of data collected during each study. As participants recounted their alcohol experience during qualitative interview, many reported changes in their perception of self over time, often comparing the person they *were* to the person they now *are*. *Soberistas* participants spoke of these changes alongside their engagement with the site; cohort study participants reflected on the impact of an unscheduled hospital attendance on their sense of self and supported their narratives with the selection and placement of different 'alcohol discs' in the PRISM task. In addition to this retrospective evidence of change, participants' scores for items relating to drinking identity on the SOCRATES demonstrated significant changes between baseline and six-month follow-up (Page 161); this occurred alongside highly significant changes in measures of alcohol consumption, levels of dependence, psychological distress, and alcohol problem awareness (Page 117). Finally, participants' conceptualisations of alcohol use and self were even challenged or refined *during* the research interview, despite this never being my intention (recall Barbara who said, *"I have never looked at it that way, that has put a totally different perspective on it"*; see Page 168).

10.3   General strengths and limitations

The specific strengths and limitations of each study were discussed in summary sections at the end of corresponding results chapters. More general strengths and limitations that relate to the overall research design and approach are now considered.

Studies of addiction and recovery often recruit treatment-seeking clinical populations from specialist services or traditional mutual aid groups underpinned by 12-step philosophy. Many

clinical trials testing new interventions also adhere to tightly controlled eligibility criteria, excluding many patients seen in usual care (Blanco *et al.*, 2008), and short-term pre- and post-intervention studies assume change to be linear and unidirectional (Kougiali *et al.*, 2017). This has contributed to a narrowed understanding by researchers, treatment providers, and the wider public, of what life is like with, and beyond, a problematic relationship with alcohol (Andréasson, 2012; Cunningham and McCambridge, 2011; Khadjesari *et al.*, 2018). A key strength of the work presented in this thesis is that it allowed the voices of those largely absent in the literature to be heard; they were then deliberately incorporated into all stages of the research process to develop a grounded theory understanding of participants' experiences.

The use of mixed-methods, underpinned by pragmatist philosophy and grounded theory principles, is another key strength. I employed a range of qualitative and quantitative methods (e.g. in-depth face-to-face and telephone interviews, a graphic elicitation task, completion of self-reported questionnaire measures, calculations of statistically *and* clinically significant change) to explore the change process through multiple lenses. The use of one method alone would have limited any insights (Creswell and Plano Clark, 2011). Grounded theory also permitted freedom to explore unanticipated areas of literature across a range of disciplines including psychology, medicine, and sociology. Although I searched for literature systematically, I did not conduct a systematic review, which may have resulted in the omission of relevant literature. However, flexibility in this regard is a significant strength of the grounded theory approach, as it ensures the concerns of participants, rather than concerns of the researcher, provide the direction for further study (Charmaz, 2014).

Nevertheless, a caveat of all qualitative research is its subjectivity[13]. All studies relied on participants' self-report and questionnaire responses/narratives were not verified. It is also possible, indeed likely, that a different researcher would have taken a different theoretical perspective, asked different questions, and selected different participants for interview; this would have resulted in the development of a different theoretical framework. I therefore acknowledge my role as researcher in constructing knowledge and meaning, in collaboration with the participants in my studies. I have deliberately presented an "interpretive portrayal of the studied world, not an exact picture of it" (Charmaz, 2014, p.17), which accords with a

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[13] Although quantitative research is subject to the same criticism; indeed, the development of quantitative measures and tools, and the decisions taken to analyse the data they produce, are at the hands of human subjects who approach the task with their own set of values, agendas, and beliefs (see Dwyer and Fraser (2015;2016) for an interesting discussion of this within the addiction field specifically).

constructivist approach to grounded theory and aligns with the pragmatist position of multiple realities.

It should also be acknowledged that my analyses were exploratory, based on a limited number of interviews with individuals in specific settings at a given point in time. This limits empirical generalisability, and caution should be taken in applying these findings to other populations or settings. Moreover, due to the limitations of existing measures of alcohol/recovery identity, I decided not to administer these within the hospital cohort study at baseline and follow-up. However, this restricts the conclusions that can be drawn about participants' identity change, evidence of which relied heavily on retrospective self-report by individuals who were willing and able to discuss their relationship with alcohol; their experiences may differ from individuals not in a position to do so, and retrospective accounts of identity change may not correspond with changes that are observed when measured prospectively.

Despite these limitations, purposive sampling was used to recruit individuals with a maximum variation of characteristics to garner diverse perspectives. Detailed information about the characteristics of participants have been provided to allow the reader to judge their representativeness when compared elsewhere, and I have highlighted areas of agreement and disagreement with other research. I also sought input from various sources throughout all stages of my work to ensure my findings demonstrate "credibility", "originality", "resonance" and "usefulness" (Charmaz, 2014, p.336-338). For example, study protocols and findings were presented at local, national, and international conferences to receive feedback from diverse audiences of clinicians, commissioners, and researchers; I discussed my work with lay experts and individuals with lived experience; and parts of this work have been submitted to and published in peer reviewed journals.

10.4 Key messages

With the theoretical model, and the strengths and limitations of my research outlined, I now discuss the key messages that can be taken from my findings and detail their implications for future research and clinical practice.

10.4.1 Change is complex

Although my analysis identified certain factors that were associated with change, the heterogeneity and complexity of individual experience makes the development of robust risk profiles for change in those with AUD difficult. Adding to the difficulty of predicting change, is that 'independent' predictive factors are seldom truly independent (Kraemer *et al.*, 2001). Indeed,

recent research finds that lifestyle factors in patients with AUD often "cluster" together, making their independent effects hard to discern (Schwarz, Nielsen and Nielsen, 2018). Moreover, treatment seeking is rarely driven solely by a desire to address problematic alcohol consumption (Orford *et al.*, 2006b); it is often associated with a myriad of actual or feared consequences in other domains of life. *Soberistas* participants, and those with treatment histories in the hospital study, discussed the impact on family and work life, and physical and mental health, for example. Thus, finding that baseline treatment engagement predicted unfavourable outcomes at six months is only one piece of the puzzle in our understanding.

The lack of association between motivation and outcomes also contributes to my assertion that change is complex. It is in some ways encouraging that low motivation may not necessarily mean poor outcomes for hospital patients with AUD. However, it raises questions about the goal of interventions delivered in this setting, and the place of self-reported measures of motivation if they do not reliably predict outcomes (de Vocht *et al.*, 2018). Many readiness questionnaires (including those used in this work) are based on the transtheoretical model (TTM) of change, which assumes a sequential progression through stages. The model is unable to account for situations in which individuals transition straight from 'precontemplation' to 'action', such as during a hospital admission, a point West (2005) raised over a decade ago. As Sellman (2010) notes, it is not unusual for change to come in the form of "dramatic epiphanies" which are seemingly unpredictable and independent from variables that can be measured, including readiness.

The model presented in Figure 14 recognises the complexity of the change process by highlighting the influence of multiple factors, and the dynamic effect they can have on an individual's sense of self, relationship with alcohol and experience of recovery.

10.4.2   "Not everything that counts can be counted, and not everything that can be counted, counts" (attributed to Albert Einstein)

The effectiveness of interventions, from brief advice to specialist treatments, are often determined by reductions in consumption (Public Health England, 2017; Witkiewitz *et al.*, 2017), and as discussed in Chapter 1, many definitions of 'recovery' refer to quantifiable outcomes across a range of domains in functioning, e.g. (Belleau *et al.*, 2007; United Kingdom Drug Policy Commission, 2008). My quantitative analyses were conducted accordingly and provided some insight into the degree of measurable change between two time points. However, this type of analysis offers limited information about *how* and *why* a person changes (Best *et al.*, 2016).

Participants' qualitative narratives illustrated the subtleties and unquantifiable aspects of change, such as the impact of philosophical assumptions about recovery, transitions in identity, and the consequences of labelling. My analysis also recognised the struggles associated with recovery from a problematic relationship with alcohol, which led to exploration of the 'posttraumatic growth' concept, an area that has attracted surprisingly little research attention within the addiction field (Haroosh and Freedman, 2017; Krentzman, 2013). Personal growth, whether in the form of positive identity change, increased confidence, compassion, or awareness, should be 'counted' when measuring change, even if it occurs alongside continued drinking or during episodes of relapse (c.f. Kougiali *et al.,* 2017). Shifts in any part of the 'cog system' (Figure 14) may therefore be considered a form of personal growth as the individual refines their understanding of self and their relationship with alcohol. As Milo asserted:

> "*I never, ever stop learning about myself. When I relapsed last year, I lost my clean time, but I didn't lose my knowledge.*" (Page 214)

Personal stories of the processes of change should therefore be gathered alongside quantitative evidence of change, to capture the nuances of lived experience. Related to this, other researchers (and clinicians) could make use of visual mapping and graphic tasks, like the PRISM (Büchi *et al.*, 1998), to elicit contributions from participants that are difficult to articulate in words or capture quantitatively.

However, if quantitative measures and tools are used to 'count' experiences of addiction and recovery, involvement from those with lived experience at the development stage is crucial. As Dwyer and Fraser (2016) argue, screening and diagnostic tools can play an active role in "making the phenomena they purport to track" (p.223) as individuals learn to describe and reduce their experiences according to the language of such measures. Patient involvement is therefore essential to ensure items accurately capture and reflect their personal experience; failure to do so can result in meaningless, unreliable, and inappropriate outputs (Neale and Strang, 2015). I encountered examples of this during my work, including numerous participants who expressed discontent about the SOCRATES item supposedly measuring 'problem perception' which states: "I am an alcoholic".

My findings support the need for further examination of identity processes within addiction and recovery, but there has not been enough systematic work with individuals with lived experience to know how to best measure this construct. Despite this, several emerging 'identity questionnaires' are being used in alcohol research (although mainly with undergraduate/college students), most of which have been adapted from work with other populations, including smokers (Lindgren *et al.*, 2017). Having incorporated some items from these questionnaires into qualitative

interviews for exploratory purposes, I suggest that much more work is needed to assess their suitability and acceptability before they are used routinely with clinical populations. By way of example, when I asked one participant "are you proud to be a drinker?", an item used in work by Frings et al. (2016), he replied:

> *"Am I proud to be a drinker? Is that what it's called… 'being a drinker'? Are you a drinker? Do you like being a drinker? What a bloody strange question."*

10.4.3 Alcohol and recovery identities are diverse and amenable to change

The findings in this thesis highlight that conceptualisations of alcohol, recovery, and self, are continuously shaped by a multitude of factors (see Figure 14), and these conceptualisations guide individuals in choosing treatment/recovery approaches that align with their needs and philosophical assumptions at a given moment in time. However, individuals can only select from the discourses and approaches available to them, and research suggests that currently, options are limited (Khadjesari *et al.*, 2018; Wallhed-Finn, Bakshi and Andréasson, 2014). Researchers might therefore explore the multiple narratives of addiction and recovery which can inform new treatments, widening the possibilities for individuals to choose how they define their identity and resolve a problematic relationship with alcohol. If individuals then have the chance to match themselves to a range of different treatment options *over time*, it may improve retention, adherence, and outcome (Hell *et al.*, 2018), and lower the 'treatment utilisation gap' (Drummond *et al.*, 2011; Public Health England, 2017).

Importantly, however, my findings affirm that much of recovery takes place outside of healthcare and specialist treatment settings. Participants whose narratives suggested evidence of recovery and/or personal growth (through arriving at a stage of contentment, authenticity, freedom etc.), had often described finding new "ways of being" (cf. Hughes, 2007). This suggests that identity is indeed bound up with behaviours, physical and mental health states, routines, and group memberships. Individuals who took steps to address unhealthy practices or had developed fresh or renewed interests that extended beyond alcohol use and recovery, appeared to experience great benefits. While participants were clear that their relationship with alcohol had undoubtedly shaped who they are, many of their narratives illustrated that it did not have to permanently *define* who they are; I hope this might bring encouragement to individuals, and their families, in the throes of addiction and severe dependence.

10.4.4   Recommendations for future research

A number of interesting avenues for future research have been described throughout this thesis, that might extend the specific findings of each study. For example, my work with *Soberistas* highlighted a gap in understanding about how males use online groups to support recovery, as my findings were based on interviews mainly conducted with women (Chapter 4). Regression analyses performed on data collected as part of the hospital cohort study (Chapter 6) highlighted the need to further explore the relationship between first-time alcohol assessments in hospital and favourable outcomes, and baseline treatment engagement and poor outcomes; further mixed-methods research into the interactions and overlap between predictive factors would help us understand their combined impact and preserve the complexity of individual experience (Kraemer *et al.,* 2001). Moreover, analysis of qualitative narratives suggested that the 'posttraumatic growth' concept might have relevance for addiction recovery, but as research in this area is in its infancy, more work is needed to explore the feasibility and acceptability of incorporating a framework of positive psychology within and across the care system.

Moving beyond recommendations borne out of the separate studies within this thesis, I now turn to a discussion of steps that may be taken to enhance and test the overarching theory of alcohol and recovery self-concept fluidity. Crucially, prospective mixed-methods longitudinal research is required to investigate how alcohol and recovery identities change over time, and alongside measures of alcohol consumption, dependence, quality of life and wellbeing, treatment engagement etc. The PRISM task may be incorporated into this type of study design and used as its intended purpose of a quantitative measure of the degree of intrusion of alcohol on self, or as a qualitative measure to elicit subjective experience of change. This would give further insight into the context surrounding, and predictors of, identity change.

Prior to this however, new identity questionnaire(s) need to be developed that properly capture diverse views and experiences of addiction and recovery. The data presented in this thesis might assist in the generation of a comprehensive list of items relating to alcohol/recovery identities that can then be tested as part of questionnaire development. However, it may also be beneficial to identify a typology of drinking and recovery identity using a more structured and systematic approach than in-depth interviews, such as Q-methodology (Stenner, Watts and Worrell, 2008). This method uses by-person factor analysis to group participants who sort a comprehensive list of statements (in this case, about alcohol/recovery identities) in comparable ways; as 'exemplars' are identified within each factor, this analysis can inform the inclusion of key questionnaire items in a final 'identity scale'. For example, the statement, *"my drinking is a medical problem"*, may be chosen to represent a category pertaining to the conceptualisation of addiction as a 'disease' if it

is found to load significantly (and only) onto that factor. Moreover, if discrete conceptual categories of alcohol and recovery identity could be established, it would be possible to track if and how an individual moves between them over time. While the Q-sort approach has been used to further understand 'smoker' and 'vaping' identities (Farrimond, 2017; Farrimond, Joffe and Stenner, 2010), I am not aware of any research looking at conceptualisations of identity within alcohol populations.

Finally, further work is needed to understand the concept of 'biographical disruption' in the context of recovery from problematic alcohol use. Knowledge of the properties of biographically disruptive event(s) will help to explain the differential effects in their ability to shape an individual's sense of self and behaviour. Research could examine a range of significant life events (e.g. an unscheduled hospital attendance, the loss of a job or relationship), alongside more subtle moments that prompt increased awareness of the detrimental effects of alcohol use. Moreover, understanding the characteristics of individuals most likely to report certain events or moments as 'disruptive', might assist in the person-centred optimisation of such events for sustained recovery.

10.4.5   Implications for clinical practice

The finding that conceptualisations of problematic alcohol use and recovery are diverse and subject to constant (re)negotiation has implications for the way we consider and treat individuals with AUD. Firstly, individuals should be encouraged explore their relationship with alcohol and recovery from a range of perspectives and frameworks, in order to align themselves to the approach most suited to their needs *at the time*. However, as discussed at length in Chapter 7 (see Section 7.5), individuals often feel overwhelmed when trying to make sense of their experiences within the context of conflicting frameworks of addiction and recovery. Treatment providers and healthcare professionals can assist individuals in this process in a supportive and non-judgement way, within a system that allows for flexibility and change. This may involve education or discussion around various conceptualisations of addiction and recovery, or signposting to a range of support services that are underpinned by different philosophies.

Secondly, my data make salient the impact of language and terminology on perceptions of substance use problems, and individuals' willingness to seek help. Many participants spoke of the detrimental effects of being permanently labelled an "alcoholic", for example. Barriers to help-seeking may be attenuated if care is taken to avoid stigmatising language when discussing problematic alcohol use. Moreover, within a model of self-concept fluidity, it is to be expected that an individual may change the way they self-label over time; my findings suggest that the

ability to do so without negative consequence is key to a person-centred approach to care for those with AUD.

Another implication for practice is the benefits of encouraging and facilitating wide interests beyond alcohol use and recovery. This recommendation stems from participants' narratives about the detrimental sequels of loneliness and boredom on recovery progress, and the positive effects of a complex self-concept with multiple domains of self, found in this work and that of others'. Participants described numerous activities and practices they found helpful for improving wellbeing, sense of self, respect for self, and confidence to sustain reduced drinking/abstinence, which may be suggested as options for others looking to move beyond a problematic relationship with alcohol. For example, participants described benefit from activities including sport, further study, beauty treatments, meditation, voluntary work, cooking, walking, gardening, photography, and knitting. Facilitating increased involvement in activities provided outside of treatment and healthcare settings aligns with models of positive psychology, such as 'social prescribing', discussed at the end of Chapter 9.

Interviews with patients attending hospital highlighted specific implications for professionals working in such settings (see Section 6.6 in Chapter 6, and Chapter 8, for full discussion). For example, that baseline motivation was not associated with drinking at six months, suggests clinicians should not consider overt lack of motivation to change, a proxy for poor outcomes. Given the current uncertainty in predicting for whom and when an event, such as hospital attendance, might represent a biographical disruption that causes a shift in thinking and behaviour, staff are encouraged to optimise the "window of opportunity" to engage all patients in supportive discussions of their alcohol use (Roper *et al.*, 2013). However, this may be particularly relevant for individuals who experience a first-time assessment of alcohol use in hospital, given the apparent impact this had for participants in the present study. Clinicians may therefore wish to ask patients about their history of alcohol assessments, a timely recommendation following the launch of the recent alcohol Commissioning for Quality and Innovation (CQUIN) in hospitals, which is likely to identify a significant number of risky drinkers for the first time. These results have been presented to several clinical teams and practitioners locally, where Southampton General Hospital is the site of a case study for the CQUIN. My findings also suggest that many patients would welcome continued support after discharge, but only a minority were signposted or directly referred. Strengthened working relationships between clinical teams within hospitals and clearer treatment pathways are therefore needed to bridge care between hospital, and specialist community and other support services.

10.5   Conclusion

The work within this thesis was conducted under the Wessex Academic Health Science Network's (WAHSN) 'reducing harm from alcohol' programme, which aimed to "take a fresh look at how we identify and treat alcohol problems" (2015). My research provides fresh insight into how problematic alcohol use and recovery can be conceptualised by gaining the perspectives of individuals whose voices are largely absent in the literature. Analysis of their narratives resulted in a theoretical model that highlights the dynamic, fluid, and complex nature of change, and contributes to my position against a single ideological approach to problematic alcohol use and recovery. This stance mirrors that of Savic and Lubman (2018) who recently argued:

> "Rather than narrow and uniform models of addiction that promote overly simplistic thinking and 'one-size fits all' responses, it would be better to engage with the complexity and diversity of peoples' experiences (and the forces that shape these) to better tailor responses to clients' needs." (p.1)

The work for this thesis has given rise to many more questions which can only be answered through further research. However, the findings have consolidated my belief in the need to involve individuals with lived experience, actively and meaningfully, in the research process, which may ultimately shape their future care. Any recommendations proposed for future research throughout this thesis, are therefore tentative suggestions which require validation from those that the work seeks to represent. By fully incorporating their expertise, changes in alcohol and recovery discourses are more likely, and should facilitate the development of diverse and tailored interventions to reduce stigma and normalise help-seeking.

APPENDICES

Appendix A   Topic guide for *Soberistas* interviews

<table>
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INTRODUCTION

- Could you tell me a little bit about yourself? Maybe a bit about your life before Soberistas (Job / family / brief overview of alcohol use)
- Did you ever seek treatment before joining Soberistas? Or use any other forms of support? Did it ever work? Why / why not?

</td></tr>
<tr><td>

SOBERISTAS

- So what was going on in your life when you found Soberistas?
- How did you hear about it?
- Why did you join Soberistas? What did you expect / hope for?
- How long have you been a member?
- How often do you use the site? When? At particular times?
- What do you get out of being a member?
- What do you feel is the best aspect of Soberistas?
- Is there anything you don't like?
- Have you looked at any of the stories other people have shared? Do you find them helpful? Do you relate to anything others say on the website? Have you told your story?
- What do you think about it being online?
- Would you/have you met people in person?
- What is the culture of Soberistas? Does it promote total abstinence? Would you be honest if you drink?
- What do you think about it being a mainly female site?
- Do you ever talk about Soberistas with other people (outside of Soberistas)? If NO: Is there any reason why you don't? If Yes: With whom? What do you tell them about it? What do they think? How would you describe these conversations?
- How would you explain Soberistas to someone who hadn't heard about it before?

</td></tr>
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ALCOHOL

- Are you currently drinking? NO: How long have you been alcohol-free for? YES: When was your last drink?
- What does the phrase "turning point" mean to you? Have you experienced this?
- Did other people know about your drinking?
- Where did Soberistas fit into your journey?
- Since joining Soberistas, have you changed how you think about alcohol?

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Appendix B   Topic guide for hospital qualitative interviews

INTRODUCTION

- Can you tell me a bit about yourself?
- When did you first start drinking?
- When did you first become concerned about your drinking?
- Before your hospital admission in {insert month}, had you accessed any support for your drinking? *(Probe GP, AA, community services, rehab etc.)* Why/why not? If yes, did you find it helpful?

HOSPITAL

Researcher will have copies of questionnaire measures completed by the participant during their hospital attendance to use as prompts if necessary.

- Can you remind me what led to your hospital admission in {insert month}?
- What was going on in your life at the time?
- Can you remember how much were you drinking around the time you were in hospital?
- What impact did being in hospital have on you? *(Probe impact physically, emotionally, mentally, and impact on drinking behaviour – refer participant to PRISM task (see protocol) if it helps them to explain)*
- How did you find it talking about your alcohol use with staff?
- Some people have said that being admitted to hospital was a "turning point" which helped them decide to cut down or stop drinking – what do you think about this?
- Did your thoughts about alcohol change because of being in hospital? If so, how / why?

POST-DISCHARGE

- What has life been like since being discharged from hospital?
- Has your drinking pattern changed at all? *(Probe in what ways / why / when? Again, refer participant to PRISM task if it helps them to explain, and also their answers to questionnaire measures from Phase I which assessed drinking patterns)*
- Have your values changed since leaving hospital? What is important to you now?
- Have there been any changes in your social life?

QUESTIONS CAPTURING GENERAL THOUGHTS ABOUT ALCOHOL & IDENTITY

- What do you think of the word "alcoholic"? Are there any other labels you or others might use to describe people who drink? What do you think about these terms?
- Do you / did you like being a drinker?
- Are you proud to be a drinker?
- How important is / was drinking to who you are /were as a person?
- Is drinking part of who you are?
- What do you think causes people to drink problematically?
- What does the word "recovery" mean to you?
- Are you able to see yourself as a non-drinker?
- Where do you see yourself in the future?

Appendix C   Line-by-line coding example

Excerpt from a *Soberistas* interview transcript **I: Interviewer** P: Participant	Coding
I: So you mentioned you thought your GP might say go to AA, did you ever consider that? P: Yes I did consider that, erm much more recently. Erm, probably around May time of this year, because I realised the drinking was getting hold of me and that I couldn't not have it and that I would have to do something, and I realised going to AA in practical terms, alright it's doable but the nearest one is 20 miles away because of where I live so I couldn't just go round the corner...but then you'd have people that you know...so I thought if I can't stop I'm going to have to do that and then I'd seen a Mail article and seen the Soberistas thing and that was in the back of my mind and I thought that's another option. So I mulled around my options for quite a little while. **I: And you said it started to get hold of you, how did that feel?** P: Because I felt a compulsion to drink at night, I couldn't *not* do it, as soon as I would come in from work, sometimes I work late shifts, but the first thing I would do is straight to the fridge for the wine and that started to worry me. Definitely. **I: Ok so please can you tell me a bit more about how you found Soberistas?** P: How I found it you say? **I: Yeh...** P: There was an article about drinking, it may have been about Lucy Rocca, I can't remember exactly what it was, but the name, it was a jolly catchy name and it stuck in my head and so I kind of thought well that might be some tools to put	Considered going to AA Why? *"drinking was getting hold of me"* – losing control, compulsion to drink Needing to do something about drinking Would go to AA despite long journey Not wanting to be recognised locally AA as a last resort Finding Soberistas – newspaper Contemplating different options for help *"Compulsion to drink"* – dependence? Drinking around work pattern Concern about drinking: *"worry"* Drink choice – wine Finding Soberistas – newspaper article First impressions of Soberistas: *"catchy name"* Expectations of Soberistas: *"tools to put in my box"*

in my box if ever I felt I could do with it. I had tried to stop drinking last January erm for the Macmillan thing you know they were running a scheme, and I thought well I won't drink in January, and I think I managed 1 night and then I ended up drinking again.	Previous attempts to quit – dry January Relapse back to drinking
I: And how did it feel when you were first looking round the website?	
P: Er how did it feel, oh absolutely, I was intrigued and erm, I thought well this is definitely worth me giving it a try so I thought I would try it for 3 months to see what happens and if then I'm still drinking I'm going to have to go to AA, however far it is.	First impressions of Soberistas – *"intrigued"* Trailing Soberistas (3 month subscription) AA as a last resort
I: Ok, so when did you join?	
P: I think it was July, yeh it was July.	Length of membership
I: So quite new...	
P: Yeh.	
I: And what did you hope for when you first joined?	Hopes for Soberistas
P: I hoped that I would find likeminded people who had similar problems and had achieved sobriety...and I did.	Finding likeminded people / Sharing experiences Inspiration from those already sober
I: And why did it feel important to find likeminded people?	
P: Because erm, I think it's much easier to feel supported and give support with people who...you might say singing from the same hymn sheet. Er I mean what was especially helpful for me was finding the 'young at heart' or '60 and sober', whatever it is called. I've joined that little thread. I am the eldest...in fact I'm probably the eldest in the whole thing but I don't really care. I mean some people are 60, 67, so we have all had life experiences, all of us have grown up families and it just feels so supportive and happy, so that's why I wanted to do it because I felt somebody would understand. They wouldn't preach at me.	Mutual support Finding likeminded people Finding a smaller community Self-description (age) Not caring about age – inclusivity Sharing common experiences Supportive / Feeling *"happy"* on Soberistas Reason for joining – Feeling understood Non-judgemental – *"wouldn't preach"*
I: How often do you go on the site?	

P: Oh god [laughs] well this is the thing...I think i'm becoming addicted to the blinking site! At the moment, invariably twice a day. At least daily absolutely.	Becoming addicted to Soberistas Time spent on the site – daily use
I: And what parts of the site do you use apart from the thread you already mentioned?	
P: Well I read the you know blogs, I think I've only responded once to anybody because I don't want to get sucked into another sort of group because I also have to live my life and I wouldn't have the time apart from anything else [laughs]. Er but I am so at home in the group I'm in that I just kind of occasionally look at what other people are up to and that's all.	Blogs Reasons for not contributing: Time-consuming / *"have to live my life"* (online/offline divide) Feeling *"at home"* Limited interaction with main site Finding a smaller community
I: Ok...and how did you find the group you're in?	
P: Oh I was just looking at the general discussion board and I looked at the list. I presume you've been on the site to see how it works?	*"Browsing"* on the site Finding similar others
I: Yes, I have had a look around so I understand roughly how things work.	
P: Ok. So I was just browsing around, looking at general discussions, saw one that said, 'any 60 young at heart 60's' out there, or something like that. Er I also put out a thing for meeting up right at the beginning because I just thought, oh if I could meet somebody er that would be helpful. You're going to ask me why aren't you [laughs]? Well two people...you know in my area because you know I am isolated here, and two people responded, but I have briefly met up with, the other one we have agreed to meet but as yet haven't done that yet.	Contacting other members *("put out a thing")* Meeting up with other members Going beyond online contact Feeling isolated in real off-line life Meeting up with other members
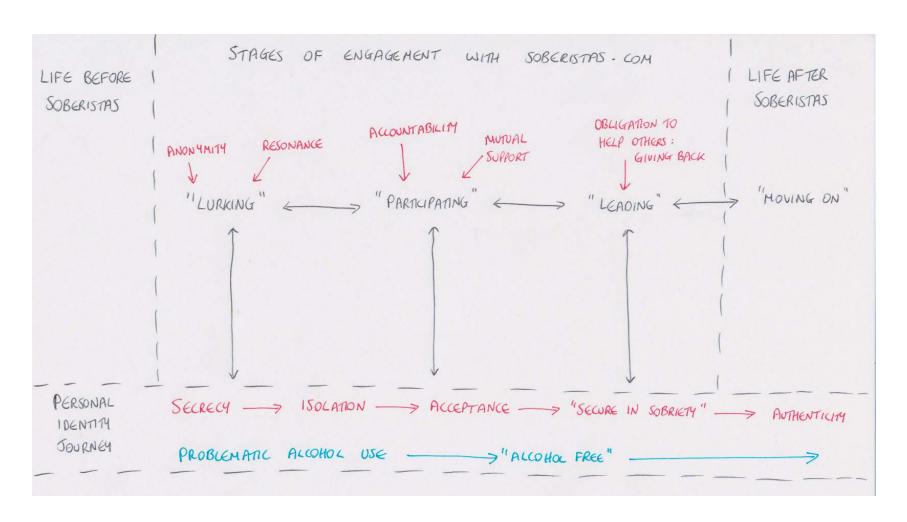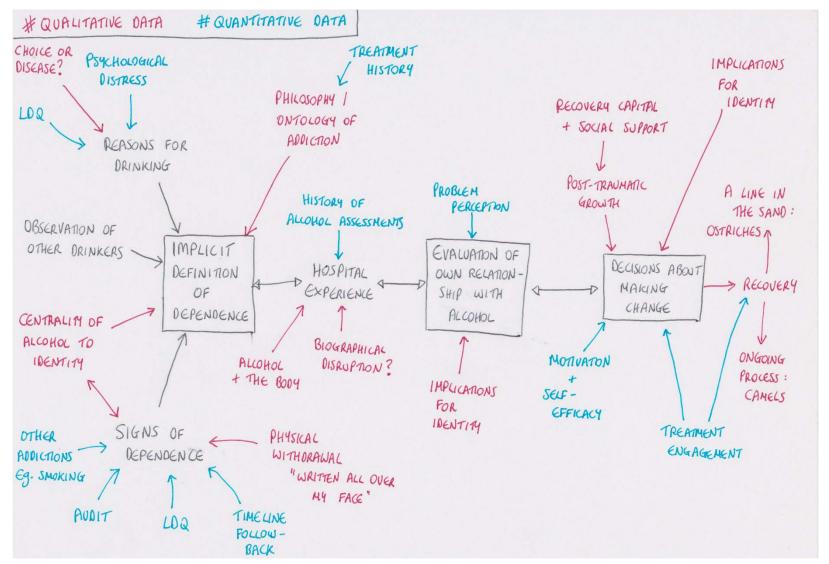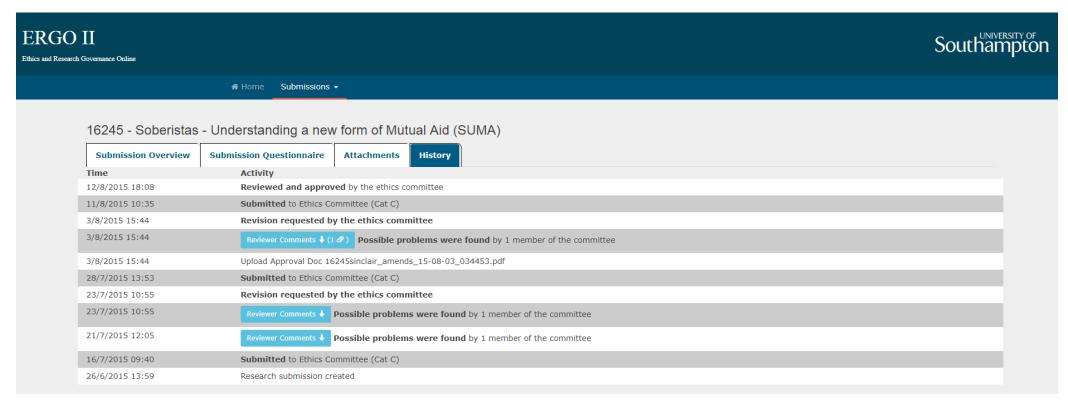
Appendix D   Examples of visual mapping

QUALITATIVE DATA   # QUANTITATIVE DATA

CHOICE OR DISEASE?

PSYCHOLOGICAL DISTRESS

LDQ

REASONS FOR DRINKING

TREATMENT HISTORY

PHILOSOPHY / ONTOLOGY OF ADDICTION

IMPLICATIONS FOR IDENTITY

RECOVERY CAPITAL + SOCIAL SUPPORT

OBSERVATION OF OTHER DRINKERS

HISTORY OF ALCOHOL ASSESSMENTS

PROBLEM PERCEPTION

POST-TRAUMATIC GROWTH

A LINE IN THE SAND: OSTRICHES

IMPLICIT DEFINITION OF DEPENDENCE

HOSPITAL EXPERIENCE

EVALUATION OF OWN RELATION-SHIP WITH ALCOHOL

DECISIONS ABOUT MAKING CHANGE

RECOVERY

CENTRALITY OF ALCOHOL TO IDENTITY

ALCOHOL + THE BODY

BIOGRAPHICAL DISRUPTION?

MOTIVATION + SELF-EFFICACY

ONGOING PROCESS: CAMELS

IMPLICATIONS FOR IDENTITY

OTHER ADDICTIONS Eg. SMOKING

SIGNS OF DEPENDENCE

PHYSICAL WITHDRAWAL "WRITTEN ALL OVER MY FACE"

TREATMENT ENGAGEMENT

AUDIT   LDQ   TIMELINE FOLLOW-BACK

Appendix E   University ethics approval for *Soberistas* study

Time	Activity
12/8/2015 18:08	**Reviewed and approved** by the ethics committee
11/8/2015 10:35	**Submitted** to Ethics Committee (Cat C)
3/8/2015 15:44	**Revision requested by the ethics committee**
3/8/2015 15:44	Reviewer Comments ⬇ (1 📎) **Possible problems were found** by 1 member of the committee
3/8/2015 15:44	Upload Approval Doc 16245sinclair_amends_15-08-03_034453.pdf
28/7/2015 13:53	**Submitted** to Ethics Committee (Cat C)
23/7/2015 10:55	**Revision requested by the ethics committee**
23/7/2015 10:55	Reviewer Comments ⬇ **Possible problems were found** by 1 member of the committee
21/7/2015 12:05	Reviewer Comments ⬇ **Possible problems were found** by 1 member of the committee
16/7/2015 09:40	**Submitted** to Ethics Committee (Cat C)
26/6/2015 13:59	Research submission created

Appendix F   Participant information sheet for *Soberistas* study

Study Title: Soberistas – Understanding a new form of Mutual Aid (SUMA) Phase II

Researcher: Sophia Chambers, Dr Krysia Canvin, Dr Julia Sinclair

ERGO number: 16245

Please read this information carefully before deciding whether or not to take part in this study. If you are happy to take part you will be asked to say that you agree to the interview when the researcher calls you – this will be recorded.

What is the research about?

We are a team of researchers from The University of Southampton. The research is funded by Wessex Academic Health Sciences Network and an Enterprise Innovation Grant awarded to Soberistas. It is sponsored by University of Southampton.

Unfortunately, alcohol is the third leading risk factor for disease across the world. In the UK a quarter of the population drinks in a way that is potentially or actually harmful. We are looking at how Soberistas helps people change their problematic alcohol use.

Why have I been chosen?

As a Soberistas member who recently took part in the online survey, we are interested in hearing more about your views on the network and how it helps you understand your own relationship with alcohol and potentially how to change it.

What will happen to me if I take part?

You will be contacted by phone to discuss any questions you may have and to arrange a telephone interview with a member of the research team. You will be asked for your opinion about the various aspects of the website and your own relationship with alcohol. The interview will take 30 - 60 minutes to complete.

Are there any benefits in taking part?

There are not likely to be any personal benefits to completing the interview. However, it will help improve our understanding on people's relationship with alcohol and what factors have an impact

on their ability to change. You will be offered a £10 Amazon e-voucher as a thank you for contributing your time and thoughts.

Are there any risks involved?

We do not expect that this study will have a negative impact on your psychological or physical health.

Will my participation be confidential?

Yes. The interview will be audio-recorded, but once typed-up, will be permanently deleted, other than the part where you give your consent to taking part in the interview. There will be no paper copies kept of any interviews. All data will remain confidential and will not be given to any third parties. All references to places or people will be removed, and your real name will not be included in any publications.

What happens if I change my mind?

It is okay to change your mind at any point and withdraw consent to participate. Please email the lead researcher Sophia Chambers (sec1n14@soton.ac.uk) before the interview has taken place if you no longer wish to take part or say during the interview if you would like to stop for any reason. If you decide to stop the interview, any information given prior to this point will not be included in the study.

What if something goes wrong?

We do not expect that anything will go wrong. However, if you do have any concerns about the study, please contact Cathy or the University's research office:

Cathy Rule: Project Manager (Alcohol Quality Improvement Programme)

Tel. 07990 002110 / 02382 020840

Cathy.Rule@wessexahsn.net

Research Governance Office

Tel. 023 8059 5058

rgoinfo@soton.ac.uk

Where can I get more information?

Dr Julia Sinclair

mailto:warc@soton.ac.uk

Tel. 02380 718 520

Where can I go for support?   www.soberistas.com

Appendix G   *Soberistas* study participant characteristics

Pseudonym	Gender	Age	Subscribed member?	Approximate length of membership	Drinking status at time of interview	Previous treatment history
Caroline	F	35 - 44	Yes	3 years	3 years AF	None
Kimberley	F	45 – 54	Yes	2.5 years	2 months AF	None
Sonia	F	65+	Yes	9 months	7 months AF	Outpatient alcohol service, AA & SMART
Michelle	F	45 – 54	Yes	10 months	5 months AF	Private therapy & AA
Karen	F	55 – 64	Yes	1 year	13 months AF	None
Linda	F	55 – 64	Yes	2.5 years	15 months AF	None
Angela	F	45 – 54	Yes	1 year	2 months AF	None
Julie	F	35 – 44	Yes	3 years	2 years AF	Outpatient alcohol service & AA
Ian	M	55 – 64	No	Found Soberistas ~6 months ago.	5 years AF	Other online

Appendix G

Pseudonym	Gender	Age	Subscribed member?	Approximate length of membership	Drinking status at time of interview	Previous treatment history
Sarah	F	64+	Yes	3 months	3 months AF	None
Kevin	M	55 – 64	Yes	1 year	2 years AF	None
Phil	M	35 – 44	Yes	6 weeks	6 months AF	None
Heather	F	64+	Yes	1 year	Currently drinking	AA, self-help books and homeopathy
Hayley	F	35 – 44	No	Found Soberistas ~3.5 years ago.	3 years AF	Private therapy & AA
Tina	F	45 – 54	Yes	3 months	1 month AF	None
Dave	M	35 – 44	Yes	3 years	1 year AF	Private therapy & AA
Kerry	F	45 – 54	Yes	3 years	3 months AF	AA, SMART, self-help books. Then went for 1:1 coaching (found via Soberistas)
Rachel	F	55 – 64	Yes	1 year	2 weeks AF (previously 7 years AF)	AA & hypnotherapy

Pseudonym	Gender	Age	Subscribed member?	Approximate length of membership	Drinking status at time of interview	Previous treatment history
Hannah	F	45 – 54	Yes	2 years	Currently drinking	AA
Amanda	F	35 – 44	Yes	1 year	Currently drinking	None
Louise	F	35 – 44	No	Found Soberistas ~2 years ago.	3 weeks AF	AA & 28-day inpatient rehab
Maria	F	25 – 34	No	Found Soberistas ~2 years ago.	2 years AF	None
Liz	F	55 – 64	Yes	2 years (but will not sign up again)	Currently drinking	Private therapy
Jenny	F	55 – 64	Yes	3 years	5 years AF	Outpatient alcohol service
Abby	F	25 – 34	Yes	1 year	Currently drinking	Outpatient alcohol service, AA & SMART
Laura	F	55 – 64	No	Found Soberistas ~2 years ago.	2 years AF	Hypnotherapy

Appendix G

Pseudonym	Gender	Age	Subscribed member?	Approximate length of membership	Drinking status at time of interview	Previous treatment history
Ben	M	64+	Yes	3 years	3 years AF (previously 27 years AF)	None
Yasmin	F	45 – 54	No	Found Soberistas ~18 months ago.	18 months AF	AA & private therapy
Sally	F	45 – 54	No	Found Soberistas 2 weeks ago	Currently drinking	None
Paul	M	55 – 64	Yes	2 years	Currently drinking	Outpatient alcohol service, & private therapy
Penny	F	55 – 64	Yes	2 weeks	9 months AF	Outpatient alcohol service, AA & SMART

Appendix H   Ethics approvals for hospital study: Phase I

HSC Business Services Organisation

Office for Research Ethics Committees Northern Ireland   (ORECNI)

Customer Care & Performance Directorate
Lissue Industrial Estate West
Rathdown Walk
Moira Road
Lisburn
BT28 2RF
Tel: 028 95361400
www.orecni.hscni.net

HSC REC A

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

---

03 June 2016

Dr Julia Sinclair
University Department of Psychiatry Academic Centre
College Keep, 4-12 Terminus Terrace
Southampton
SO14 3DT

Dear Dr Sinclair

Study title:	**A longitudinal observational study of patients referred to the Alcohol Care Team during an admission to Southampton General Hospital**
REC reference:	**16/NI/0100**
IRAS project ID:	**204165**

Thank you for your letter of 01 June 2016, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Mrs Katrina Greer, prs@hscni.net. Under very limited circumstances (e.g. for student research which

Providing Support to Health and Social Care

NHS
Health Research Authority

Dr Julia Sinclair
University Department of Psychiatry Academic Centre
College Keep, 4-12 Terminus Terrace
Southampton
SO14 3DT

Email: hra.approval@nhs.net

19 August 2016

Dear Dr Sinclair

Letter of HRA Approval

Study title:	**A longitudinal observational study of patients referred to the Alcohol Care Team during an admission to Southampton General Hospital**
IRAS project ID:	**204165**
REC reference:	**16/NI/0100**
Sponsor	**University of Southampton**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

University Hospital Southampton NHS Foundation Trust

Please reply to: Research and Development
SGH - Level E, Laboratory & Pathology
Block, SCBR - MP 138
Southampton General Hospital

Telephone: 023 8120 4901
Fax: 023 8120 8678
E-mail: taru.jussila-knappett@uhs.nhs.uk

Dr Julia Sinclair
University Department of Psychiatry
University of Southampton
College Keep
4-12 Terminus Terrace
Southampton
SO14 3DT

30 August 2016

Dear Dr Sinclair

ID: RHM MED1352   A longitudinal observational study of patients referred to the Alcohol Care Team during an admission to Southampton General Hospital

EudraCT:

Thank you for submitting all the required documentation to enable the Trust to confirm capacity and capability.

I write to confirm that as of 30 August 2016 University Hospital Southampton NHS Foundation Trust has the capacity and capability to deliver the above referenced study.

Please find attached our agreed Statement of Activities as confirmation as well as the list of documents to be used at site.

We agree to start this study when the sponsor, gives the green light to begin.

Please note that according to the 70 day benchmark you should aim to recruit your first patient by 1 November 2016

Please note: That any changes need to be timeously notified to the R&D office. This includes providing copies of:
. All substantial amendments and favourable opinions;
. All Serious Adverse Events (SAEs);
. NRES Annual Progress Reports;
. Annual MHRA Safety Reports;
. NRES End of Study Declaration;
. Notifications of significant breaches of GCP or protocol.

For further information regarding how to notify us of any amendments to the study please refer to the Amendments Guidance for Researchers found at http:/www.crncc.nihr.ac.uk/about_us/processes/csp.

Many thanks

Yours sincerely

Taru Jussila-Knappett
Research Governance Officer

Appendix I   Ethics approvals for hospital study: Phase II

East of Scotland Research Ethics Service *(EoSRES)*

NHS SCOTLAND
Research Ethics Service

> **Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval**

TAyside medical Science Centre
Residency Block Level 3
George Pirie Way
Ninewells Hospital and Medical School
Dundee DD1 9SY

Dr Julia Sinclair
University Department of Psychiatry
Academic Centre
College Keep, 4-12 Terminus Terrace
Southampton
SO14 3DT

Date:	15 February 2017
Your Ref:	
Our Ref:	LR/17/ES/0005
Enquiries to:	Mrs Lorraine Reilly
Direct Line:	01382 383878
Email:	eosres.tayside@nhs.net

Dear Dr Sinclair

Study title:	**Exploring change and identity in patients with Alcohol Use Disorders (AUD): A qualitative investigation of patients at University Hospital Southampton**
REC reference:	**17/ES/0005**
Protocol number:	**24567**
IRAS project ID:	**219964**

Thank you for your letter of 14 February 2017. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 13 February 2017

Documents received

The documents received were as follows:

Document	Version	Date
Covering letter on headed paper [Covering letter]	1	14 February 2017
IRAS Checklist XML [Checklist_14022017]		14 February 2017
Participant consent form [Highlighted changes]	5.0	14 February 2017
Participant information sheet (PIS) [Highlighted changes]	4.0	14 February 2017

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Covering letter on headed paper [Covering letter]	1	22 January 2017
Covering letter on headed paper [Covering letter]	1	14 February 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance letter]		06 January 2017
Interview schedules or topic guides for participants [Topic guide]	1.0	08 December 2016

NHS
Health Research Authority

Dr Julia Sinclair
University Department of Psychiatry Academic Centre
College Keep, 4-12 Terminus Terrace
Southampton
SO14 3DT

Email: hra.approval@nhs.net

15 February 2017

Dear Dr Sinclair

Letter of HRA Approval

Study title:	**Exploring change and identity in patients with Alcohol Use Disorders (AUD): A qualitative investigation of patients at University Hospital Southampton**
IRAS project ID:	**219964**
Protocol number:	**24567**
REC reference:	**17/ES/0005**
Sponsor	**University of Southampton**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Page **1** of **8**

University Hospital Southampton **NHS**

NHS Foundation Trust

Sophie Chambers
Academic centre
College Keep
Terminus Terrace
SO14 3DT

Clinical Governance
R&D Department
SCBR Level E, Laboratory & Pathology Block
Mailpoint 138
Southampton General Hospital
Southampton
SO16 6YD

Tel: 023 8079 5369
Taru.Jussila-Knappett@uhs.nhs.uk

29 March 2017

Dear Sophie Chambers

Letter of access for research
(RHM MED1407, Understanding alcohol-related hospital admissions – Exploring change and identity in patients with Alcohol Use Disorders (AUD): A qualitative investigation of patients at University Hospital Southampton *involving patient interviews with no likely impact on diagnosis or treatment)*

This letter confirms your right of access to conduct research through **University Hospital Southampton NHS Foundation Trust (UHS)** for the purpose and on the terms and conditions set out below. This right of access commences on **30 March 2017** and ends on **5 July 2019** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at **UHS** has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to **UHS** premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **UHS**, you will remain accountable to your employer (**University of Southampton**) but you are required to follow the reasonable instructions of **Dr Julia Sinclair** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **UHS** policies and procedures, which are available to you upon request, and the Research Governance Framework.

Appendix J   Participant Information Sheet for hospital study: Phase I

Title of Study: What is the impact of a hospital admission on alcohol consumption?

We would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve.

Please take time to read the following information carefully. Talk to others about the study if you wish.

Please ask if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Why is the study being done?

There is a lot of information about the health risks of drinking alcohol, and about 25% of adults drink more alcohol than the recommended weekly limit.

Clinical staff and Alcohol Care Teams in hospitals work to support people who are concerned about the impact that alcohol use is having on any aspect of their life. We would like to find out about services delivered at Southampton General Hospital. If we can collect this information, then we may be able to improve the service patients receive. If you agree to take part, your involvement would last for 6 months.

This study is part of Sophia Chambers' PhD research to gain an educational qualification.

Why have I been chosen?

We are inviting all adults over 18 who have been admitted to Southampton General Hospital and have seen a member of staff (or have been referred to the Alcohol Care Team) because of concerns about the impact that alcohol is having on their life.

Do I have to take part?

Participation in this study is entirely voluntary. It is up to you to decide whether to take part. You are able to withdraw (leave the study) at any time without giving any reason. If you decide to withdraw or not to take part in this study, this will not affect the medical care and treatment you receive.

Appendix J

What will happen to me if I take part?

We would like to interview you twice over the course of 6 months. The first interview will take place while you are still in hospital, or during an outpatient appointment with the Alcohol Care Team, and the second will be about 6 months later. The interviews will last approximately 30 minutes.

The second interview will take place over the phone or at a mutually convenient venue. This could be Southampton General Hospital or your GP surgery for example. If you cannot leave the house, it is possible for the interview to take place at your home address. If at the time, you are unable to take part in the follow-up interview for any reason, we can rearrange for a more suitable time.

Before the first interview, the researcher will take you through this information sheet and answer any questions you have. If you want to take part in the study, you will then be asked to sign the Participant Consent Form – you will be given a copy of this to keep.

Once you have agreed to take part, the researcher will start the first interview. They will ask you some questions from a series of questionnaires. Most of these questionnaires are standardised, validated and widely used in this field of research. The questionnaires contain questions about your alcohol consumption and mental health.

The study will not affect the healthcare you receive. We will not withhold any treatment, or start any new treatment because of your participation in this study. Any healthcare you received before this study will carry on as usual.

The following flow chart shows how the study will proceed:

- Recruitment to the study
- Read the Participant Information Sheet and sign the consent form

6 months later

- 2nd Interview

In addition to the interviews, we would also like to look at your healthcare records to find out a bit more about your medical history and to see what healthcare services you have used and when. You will not have to do anything for this – we can look at the records ourselves.

You may also be invited to take part in further research at the end of the 6 months but you do not need to decide whether or not to take part in this now.

What are the possible disadvantages or risks of taking part?

As this study only uses simple questionnaires about some aspects of your health and behaviour we do not believe that there will be any specific risks or disadvantages. However, some people may find some questions to be sensitive, which could cause distress.

As the follow-up interview will take place over the phone or at a mutually convenient venue, you should not have to make a special journey for the interview.

What are the possible benefits of taking part?

Some people may benefit from having a discussion about their level of alcohol use, and the information we get from this study should help improve the treatment of other people who go into hospital and are seen by staff because of concerns about the impact alcohol is having on their life.

You will be offered £10 after the follow-up interview as a thank you for taking part. Any travel expenses will also be reimbursed if necessary.

Will my taking part in the study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential and will conform to the Data Protection Act of 1998 with respect to data collection, storage and destruction. Unless there is information which puts you or others at serious risk of harm, information collected in the study will not be shared without your consent. A code number will be used to identify data about you, and we will keep the list that links codes to people's identity locked separately from the study data. Your name will not be used in any reports or publications. Records for the study will be held for 15 years.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any point and this will not affect your future care in any way. If you decide you do not want to carry on with the study, we will not ask you to take part in any future interviews. We would still like to view your healthcare records during the study period. However, we will not do so without your permission and if you wish, we will destroy any information you have provided.

Appendix J

What if there is a problem?

If you have any problems about any part of this study, you may write to (email: julia.sinclair@soton.ac.uk) or ask to speak to the researchers who will do their best to answer your questions (tel: 02380 718520). You can also contact Isla Morris (Research Integrity and Governance manager) who is based at the University but is independent from the study: rgoinfo@soton.ac.uk, 02380 595058.

If you remain unhappy and wish to complain formally you can do this through the NHS Complaints procedure. Details can be obtained through the hospital, your GP surgery, or from the NHS website. You can also contact the hospital's PALS (Patient Advice and Liaison Service) on 02381 206325 or patientsupportservices@uhs.nhs.uk

What will happen to the results of the study?

The results will be published in recognised journals and also throughout international meetings. A doctoral thesis by one researcher (Sophia Chambers) will also be published and made available in the University of Southampton library. If you would like a summary of the results please let the researcher know.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and given a favourable opinion by a Research Ethics Committee (reference number: 16/NI/0100). The study was also submitted to peer review process where it was reviewed by experts.

Further Information and Contact Details

If you would like more information about this study, please contact:

Dr Julia Sinclair, Chief Investigator

Tel: 02380 718520

Email: julia.sinclair@soton.ac.uk

Appendix K   Consent form for hospital study: Phase I

Title of Study: What is the impact of a hospital admission on alcohol consumption?

Participant ID: _____

Please read this form carefully and ask if you do not understand or would like more information.

Name of Researcher: Dr Julia Sinclair / Sophia Chambers

Please initial

to confirm

- I have read the information sheet dated 27/09/2016 (version 5) for the above study. I have had the chance to think about the information and ask questions about the study. All my questions have been answered.   **[   ]**

- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.   **[   ]**

- I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from representatives of the sponsor, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to access my records.   **[   ]**

- I give permission for the research team to look at my hospital (medical) records and access my information on the Hampshire Health Record which includes notes from my GP. I understand the research team might look at my notes throughout the whole study period.   **[   ]**

- I agree to my GP being informed of my participation in this study   **[   ]**

- I give permission for the research team to contact the locators that I provide (i.e. family or friends) in order to reach me during the follow-up stage of the study.   **[   ]**

Appendix K

- I understand that if I withdraw from the study or am unable to take part for   [   ]
  any reason (including loss of capacity), data collected before this point will
  still be used for research purposes.

- I give permission to be contacted in the future about further research   [   ]
  studies.

- I agree to take part in this study.   [   ]

Name: ………………………………………………

Signed: …………………………………………..   Date: ……………………

I, ………………………………………… (person taking consent) confirm that I have told the above

participant about this research project. I have checked that they have received the participant

information sheet from the clinical team, and have answered any questions they have asked. To

the best of my belief, s/he has understood what I have told her/him and s/he is giving free and

informed agreement.

I also confirm that I have gained informed verbal consent from the following 'locators' to use their

details only for the purposes of making contact with the above-named participant if they cannot

be contacted directly:

Name of locator 1: _____

Initial & date to confirm consent gained   [   ]

Name of locator 2: _____

Initial & date to confirm consent gained   [   ]

Name of locator 3: _____

Initial & date to confirm consent gained   [   ]

Signed: …………………………………………..   Date: ……………………

When completed, one copy to be kept by the participant and one to be kept in the researcher site file.

Appendix L   Participant information questionnaire

Part 1 – participant contact details

Name:

Address:

Date of Birth:

GP name and address:

Contact Number:

Permission to leave voicemail message?   Y   /   N

Email address:

Contact number for a relative/friend in case we are unable to contact you:

Once completed, remove this sheet from the rest of the questionnaire and store in secure file

Part 2 – general demographics

1) What is your gender?
- Male........................[ ]
- Female........................[ ]
- Other........................[ ]

  Please specify _____

- Prefer not to say...[ ]

2) What is your marital status?
- Single / never married............[ ]
- Married / Living with partner............[ ]
- Separated / Divorced........................[ ]
- Widow / Widower....................[ ]
- Other........................[ ]

  Please specify _____

- Prefer not to say....................[ ]

3) How would you describe your ethnicity?
- *White*   British..[ ]

  Irish..[ ]

  Any other White background............[ ]

- *Mixed*   White and Black Caribbean............[ ]

  White and Black African....................[ ]

  White and Asian....................[ ]

  Any other Mixed background....................[ ]

- *Asian/Asian British*   Indian..[ ]

  Pakistani..[ ]

  Bangladeshi..[ ]

  Any other Asian background............[ ]

- *Black/Black British* Caribbean..[ ]

  African..[ ]

  Any other Black background............[ ]

- *Other Ethnic groups*   Chinese..[ ]

  Any other ethnic group............[ ]

- *Prefer not to say*..[ ]

4) What is your current living situation?

- Live alone [ ]
- Live with child/children [ ]
- Live with friend(s) [ ]
- Live with partner [ ]
- Live with partner and child/children [ ]
- Other [ ]

    Please specify _____

- Prefer not to say [ ]

5) What is your main occupation?

- Away from work ill, on maternity leave,
    on holiday or temporarily laid off [ ]
- Working as an employee [ ]
- Long term sick or disabled [ ]
- Looking after the home or family [ ]
- Retired [ ]
- Self-employed or freelance [ ]
- Student or in full-time education [ ]
- Unemployed [ ]
- Doing any other kind of paid work [ ]
- Prefer not to say [ ]

6) What is your highest level of education?

- No education [ ]
- Primary education or less [ ]
- Secondary education [ ]
- College [ ]
- University [ ]
- Postgraduate [ ]
- Other [ ]

    Please specify _____

- Prefer not to say [ ]

7) Do you smoke?

Yes [ ]

No [ ]

Prefer not to say [ ]

8) Other substance use?

Yes⸺⸺⸺⸺⸺[ ]

Please specify:

No⸺⸺⸺⸺⸺[ ]

Prefer not to say⸺[ ]

9) Problematic Gambling?

Yes⸺⸺⸺⸺⸺[ ]

No⸺⸺⸺⸺⸺[ ]

Prefer not to say⸺[ ]

10) Familial Alcohol Use Disorder?

Yes⸺⸺⸺⸺⸺[ ]

Which family members?

No⸺⸺⸺⸺⸺[ ]

Prefer not to say⸺[ ]

Part 3 – use of services

11) **Which types of support have you used in order to reduce your alcohol consumption or to stop drinking completely?**

	In the last month	1-6 months ago	6-12 months ago	Over a year ago
AA				
SMART recovery				
GP				
Online support				
Community services				
None				
Other*				

*Please specify:

Part 4 – about hospital

12) **How did you come to be in hospital?**

13) **Who did you discuss your alcohol consumption with when you were in hospital?**
(e.g. Alcohol Care Team, psychiatrist, VAST, ward-based nurse)

14) What input did they have? *(leaflets, referral to services, advice)*

15) Is this the first time you have discussed your alcohol use in hospital? *(If no, please provide details of previous discussions)*

16) How did you find this discussion?

1	**2**	**3**	**4**	**5**
Very negative		Neutral		Very positive

Any comments:

17) How confident are you about making changes in your drinking?

1	**2**	**3**	**4**	**5**
Very unconfident		Neutral		Very confident

Any comments:

Appendix M   Participant Information Sheet for hospital study: Phase II

Title of Study: Understanding alcohol consumption and hospital admissions

We would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Please ask if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Why is the study being done?

This study builds on Phase I of a project that you took part in during your attendance at Southampton General Hospital around six months ago, (title: *"What is the impact of a hospital admission on alcohol consumption?"*).

We would like to hear more about your experiences and views of being in hospital, and to understand how this might have impacted on your relationship with alcohol. The questionnaire data we collected during the first study will be used to help us ask you questions, and for you to talk about your experiences without having to remember your answers from before.

This study is part of Sophia Chambers' PhD research to gain an educational qualification.

Why have I been chosen?

We are inviting participants who took part in the *"What is the impact of a hospital admission on alcohol consumption?"* study and agreed to be contacted for future research.

Do I have to take part?

Participation in this study is entirely voluntary. It is up to you to decide whether to take part. You can withdraw (leave the study) at any time without giving any reason. If you decide to withdraw or not to take part in this study, this will not affect the medical care and treatment you receive.

What will happen to me if I take part?

You will be contacted by telephone to discuss any questions you may have and to arrange a convenient time and location for the interview to take place. You will be asked about your experiences of being in hospital and your relationship with alcohol, building on the information we collected during the first study when we met you in hospital. We expect the interview to take 30-60 minutes to complete. Interviews will be audio-recorded with your permission.

What are the possible disadvantages or risks of taking part?

We do not expect that this study will have a negative impact on your psychological or physical health. However, some participants may find it difficult to talk about being in hospital or their relationship with alcohol, which could cause upset.

What are the possible benefits of taking part?

Some people may benefit from discussing their experiences of being in hospital and alcohol use, and the information we get from this study should help improve the treatment of other people who go into hospital and are seen by staff because of concerns about the impact alcohol is having on their life.

You will be offered £10 after the follow-up interview as a thank you for taking part. Any travel expenses will also be reimbursed if necessary.

Will my taking part in the study be kept confidential?

All information which is collected about you during the research will be kept strictly confidential and will conform to the Data Protection Act of 1998 with respect to data collection, storage, and destruction. Unless there is any new information which puts you or others at serious risk of harm, information collected in the study will not be shared without your consent.

Anonymised data will be entered onto password protected computers and kept on the secure University of Southampton server. All hard copies of records and consent forms will be kept in locked cabinets in locked rooms within the University's Department of Psychiatry at College Keep.

You will be assigned a unique ID number and this will be used on interview transcripts instead of your name. Interview transcripts will be kept separate from any of your personal information. The interview will be audio-recorded but once typed-up by Sophia Chambers (researcher), will be permanently deleted. Direct quotations may be included in publications following on from the study, but these will be anonymous; all references to places or people will be removed when Sophia types the interviews up, and your real name will not be included.

After analysis and write-up of the study results, interview transcripts will be archived in a secure warehouse and kept for at least ten years after the end of the study.

What will happen if I don't want to carry on with the study?

It is okay to change your mind at any point and withdraw consent to participate. Please contact Sophia Chambers (southamptonresearch@gmail.com or tel: 07881 547055) before the interview has taken place if you no longer wish to take part, or say during the interview if you would like to stop for any reason. Any data collected before you withdraw from the interview will be retained.

If you become upset during interview, you will be given the option to stop, but you may continue if you wish. The researcher has details of local services who offer support for people concerned about alcohol use; they will be happy to give you this information if you would like it. Dr Julia Sinclair is a Consultant Addiction Psychiatrist and is happy to call you after the interview if you require further assistance.

What if there is a problem?

If you have any problems about any part of this study, you may write to (email: julia.sinclair@soton.ac.uk) or ask to speak to the researchers who will do their best to answer your questions (tel: 02380 718520). You can also contact Isla Morris (Research Integrity and Governance manager) who is based at the University but is independent from the study: rgoinfo@soton.ac.uk, 02380 595058.

If you remain unhappy and wish to complain formally you can do this through the NHS Complaints procedure. Details can be obtained through the hospital, your GP surgery, or from the NHS website. You can also contact the hospital's PALS (Patient Advice and Liaison Service) on 02381 206325 or patientsupportservices@uhs.nhs.uk

What will happen to the results of the study?

The results will be published in recognised journals and also throughout international meetings. A doctoral thesis by one researcher (Sophia Chambers) will also be published and made available in the University of Southampton library. If you would like a summary of the results, please let the researcher know.

Who has reviewed the study?

The East of Scotland Research Ethics Service REC 2, which has responsibility for scrutinising all proposals for research on humans, has examined the proposal and has raised no objections from the point of view of research ethics. It is a requirement that your records in this research, together with any relevant medical records, be made available for scrutiny by monitors from the University of Southampton and from the University Hospital Southampton NHS Foundation Trust, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

Further Information and Contact Details

If you would like more information about this study, please contact:

Dr Julia Sinclair, Chief Investigator

Tel: 02380 718520

Email: julia.sinclair@soton.ac.uk

Appendix N   Consent form for hospital study: Phase II

Title of Study: Understanding alcohol-related hospital admissions

Please read this form carefully and ask if you do not understand or would like more information.

Name of Researcher: Dr Julia Sinclair / Sophia Chambers

	Please initial to confirm

- I have read the information sheet dated 14/02/2017 (version 4) for the above study. I have had the chance to think about the information and ask questions about the study. All my questions have been answered.   **[   ]**

- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.   **[   ]**

- I understand that if I withdraw from the study or am unable to take part for any reason (including loss of capacity), data collected before this point will still be used for research purposes.   **[   ]**

- I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from representatives of the University of Southampton or from the University Hospital Southampton NHS Foundation Trust, where it is relevant to my taking part in this research. I give permission for these individuals to access my records.   **[   ]**

- I give permission for the interview to be audio-recorded.   **[   ]**

- I agree to take part in this study.   **[   ]**

Name: …………………………………………

Signed: ……………………………………….. 　　　　　Date: ……………………

I, ……………………………………… (person taking consent) confirm that I have told the above participant about this research project. I have checked that they have received the participant information sheet, and have answered any questions they have asked. To the best of my belief, s/he has understood what I have told her/him and s/he is giving free and informed agreement.

Signed: ……………………………………..   Date: ……………………

When completed, one copy to be kept by the participant and one to be kept in the researcher site file.

Appendix O   Median scores of variables measured at baseline and follow-up (n=121)

Variables (range)	Median score at T1 (IQR)	Median score at T2 (IQR)	Median change (IQR)
Past-week unit consumption	108 (52 – 190)	20 (0 – 100)	-59 (-126 – -8)
Past-week drinking days	7 (4 – 7)	3 (0 – 7)	-2 (-6 – 0)
Past-week heavy drinking days	7 (3 – 7)	1 (0 – 7)	-2 (-6 – 0)
AUD severity (AUDIT score, 0 – 40)	31 (23 – 36)	19 (11 – 29)	-9 (-17 – -1)
Psychological dependence (LDQ score, 0 – 30)	21 (9 – 29)	9 (1 – 19)	-6 (-13 – -1)
Problem Perception (SOCRATES score, 10 – 50)	40 (33 – 45)	32 (24 – 41)	-6 (-13 – 0)
Taking Action (SOCRATES score, 6 – 30)	23 (19 – 28)	25 (20 – 29)	1 (-3 – 7)
Depression symptoms (HADS score 0 – 21)	9 (4 – 15)	5 (1 – 11)	-3 (-6 – 0)
Anxiety symptoms (HADS score, 0 – 21)	12 (6 – 17)	10 (3 – 15)	-2 (-5 – 2)

Appendix P   Median heavy drinking days (HDDs) at baseline and follow-up according to baseline characteristics (n=121)

Variables	Median HDDs at T1 (IQR)	Median HDDs at T2 (IQR)	Median change in HDDs (IQR)
Socio-demographics (n/121)			
Gender			
Male (82)	7 (3 – 7)	1 (1 – 7)	-1 (-6 – 0)
Female (39)	7 (4 – 7)	1 (0 – 7)	-2 (-5 – 0)
Relationship status			
In a relationship (28)	7 (7 – 7)	1.5 (0 – 7)	-2.5 (-7 – 0)
Single (93)	7 (3 – 7)	1 (0 – 7)	-1 (-5 – 0)
Living situation			
Lives with others (52)	7 (3 – 7)	0 (0 – 7)	-2.5 (-7 – 0)
Living alone (69)	7 (3 – 7)	2 (0 – 7)	0 (-5 – 0)
Employment status			
Employed/in education (27)	7 (7 – 7)	1 (0 – 7)	-4 (-7 – 0)
Not in work (94)	7 (3 – 7)	1 (0 – 7)	-1 (-5 – 0)
Smoking status			
Smoker (75)	7 (3 – 7)	2 (0 – 7)	-1 (-5 – 0)
Non-smoker (46)	7 (3 – 7)	0 (0 – 7)	-2 (-7 – 0)
Known familial alcohol use disorder			
Yes (62)	7 (4 – 7)	2 (0 – 7)	-1 (-6 – 0)
No (59)	7 (3 – 7)	1 (0 – 6)	-2 (-6 – 0)

Variables	Median HDDs at T1 (IQR)	Median HDDs at T2 (IQR)	Median change in HDDs (IQR)
Alcohol-related (n/121)			
Psychological dependence (LDQ score)			
Low dependence (0 – 10) (37)	3 (0 – 7)	0 (0 – 6.5)	0 (-2.5 – 0)
Moderate-High dependence (11 – 21) (84)	7 (6 – 7)	2 (0 – 7)	-3 (-7 – 0)
Problem perception (SOCRATES score)			
Low problem perception (10 – 40) (63)	6 (1 – 7)	1 (0 – 7)	-1 (-4 – 0)
High problem perception (41 – 50) (58)	7 (7 – 7)	1 (0 – 7)	-3 (-7 – 0)

Variables	Median HDDs at T1 (IQR)	Median HDDs at T2 (IQR)	Median change in HDDs (IQR)
Taking action (SOCRATES score)			
Low taking action (6 – 23) (65)	7 (3 – 7)	2 (0 – 7)	-1 (-4.5 – 0)
High taking action (24 – 30) (56)	7 (3 – 7)	1 (0 – 7)	-2.5 (-7 – 0)
Baseline alcohol treatment engagement			
Yes, in treatment (25)	7 (4 – 7)	5 (0 – 7)	0 (-6 – 0)
Not in treatment (96)	7 (3 – 7)	1 (0 – 7)	-2 (-6 – 0)
Post hospital alcohol treatment engagement			
Yes, in treatment (48)	7 (4 – 7)	1 (0 – 7)	-3.5 (-7 – 0)
Not in treatment (73)	7 (2.5 – 7)	2 (0 – 7)	-1 (-4 – 0)

Variables	Median HDDs at T1 (IQR)	Median HDDs at T2 (IQR)	Median change in HDDs (IQR)
Hospital-related (n/121)			
Direct alcohol-related admission			
Yes (91)	7 (3 – 7)	1 (0 – 7)	-2 (-6 – 0)
No (30)	6.5 (1.5 – 7)	1 (0 – 7)	0 (-4 – 0)
Context of hospital attendance			
Emergency department only (34)	7 (3 – 7)	1.5 (0 – 7)	-0.5 (-6 – 0)
Inpatient admission (87)	7 (3 – 7)	1 (0 – 7)	-2 (-5 – 0)
Assessment of alcohol use in secondary care setting			
First assessment (52)	7 (3 – 7)	0 (0 – 7)	-2 (-6 – 0)
History of previous assessments (69)	7 (4 – 7)	2 (0 – 7)	-1 (-6 – 0)
Psychological distress (n/121)			
Depression (HADS scores range)			
Low levels of depression (0 – 10) (50)	6 (1 – 7)	2 (0 – 7)	0 (-4 – 0)
High depression (11 – 21) (71)	7 (4 – 7)	1 (0 – 7)	-3 (-7 – 0)
Anxiety (HADS score range)			
Low levels of anxiety (0 – 10) (39)	7 (2 – 7)	2 (0 – 7)	-1 (-4 – 0)
High levels of anxiety (11 – 21) (82)	7 (4 – 7)	1 (0 – 7)	-2 (-7 – 0)

Appendix Q   Distribution of follow-up heavy drinking days (HDDs) data
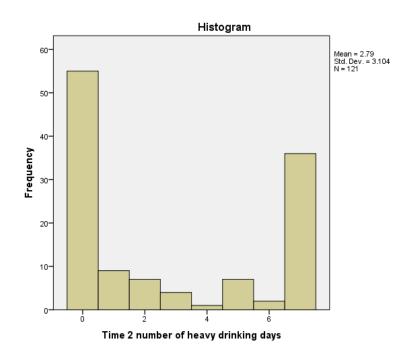
Figure 1: Histogram of follow-up (Time 2) HDDs
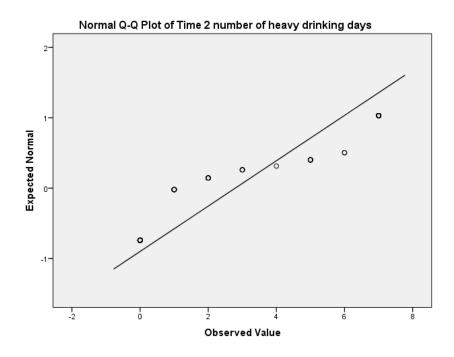
Figure 2: Normal Q-Q Plot of follow-up (Time 2) HDDs

Appendix R   Associations between baseline variables

Table 1: Correlations between continuous variables measured at baseline (r_s), n=141

	1	2	3	4	5	6	7	8	9	10	11
1. Age	–										
2. AUD severity (AUDIT score)	-.36**	–									
3. Past 6-month average alcohol consumption (AUDIT C score)	-.13	.63**	–								
4. Psychological dependence (LDQ score)	-.39**	.70**	.43**	–							
5. Past week HDDs	-.17*	.57**	.62**	.53**	–						
6. Past-week unit consumption	-.30**	.62**	.63**	.68**	.76**	–					
7. Problem Perception (SOCRATES subscale)	-.34**	.57**	.22**	.57**	.42**	.47**	–				
8. Taking Action (SOCRATES subscale)	.04	-.10	-.18*	-.08	-.07	-.16	.22**	–			
9. Self-efficacy	-.00	.05	-.02	.11	-.04	.00	.28**	.38**	–		
10. Depression symptoms (HADS subscale)	-.43**	.55**	.28**	.55**	.24**	.36**	.48**	-.07	.05	–	
11. Anxiety symptoms (HADS subscale)	-.41**	.49**	.24**	.50**	.27**	.39**	.49**	.08	.09	.76**	–

*p<.05, **p<.01

Table 2: Correlations between continuous and binary sociodemographic variables measured at baseline (r_{rb}), n=141

Variable	Gender (0=female, 1=male)	Living situation (0=lives alone, 1=with others)	Relationship status (0=single, 1=in a relationship)	Employment status (0=unemployed), 1=employed)	Current smoker (0=no, 1=yes)	Current other substance use (0=no, 1=yes)	Familial alcohol use disorder (0=no, 1=yes)
1. Age	.11	.05	.23*	-.21**	-.16	-.29**	-.17*
2. AUD severity (AUDIT score)	-.02	.02	-.02	-.02	.10	.22*	.21*
3. Past 6-month average alcohol consumption (AUDIT C score)	.09	.11	.15	.01	.02	.09	.03
4. Psychological dependence (LDQ score)	.01	-.01	-.14	.02	.15	.32**	.31**
5. Past week HDDs	-.09	.16	.17*	.13	.09	.23**	.07
6. Past-week unit consumption	.08	.09	.05	.14	.01	.30**	.10
7. Problem Perception (SOCRATES subscale)	-.09	.10	.07	.05	.02	.19*	.22**
8. Taking Action (SOCRATES subscale)	.11	.05	.16	.05	-.04	-.06	.05
9. Self-efficacy	-.04	.15	.13	-.06	-.04	-.11	.06

Variable	Gender (0=female, 1=male)	Living situation (0=lives alone, 1=with others)	Relationship status (0=single, 1=in a relationship)	Employment status (0=unemployed), 1=employed)	Current smoker (0=no, 1=yes)	Current other substance use (0=no, 1=yes)	Familial alcohol use disorder (0=no, 1=yes)
10. Depression symptoms (HADS subscale)	-.11	-.14	-.26**	-.02	.06	.19*	.13
11. Anxiety symptoms (HADS subscale)	-.16	-.19*	-.22**	.09	.04	.25**	.20*

*p<.05, **p<.01

NB: A coefficient with a negative sign indicates that the group with the highest coding has the lowest mean ranking of the two groups in terms of the continuous variable. A coefficient with a positive sign indicates that the group with the highest coding has the highest mean ranking of the two groups in terms of the continuous variable.

Appendix R

Table 3: Correlations between continuous and binary alcohol and hospital-related variables measured at baseline (r_{rb}), n=141

Variable	In alcohol treatment at baseline (0=no, 1=yes)	Treatment access during 6-month follow-up period (0=no, 1=yes)	Direct alcohol-related attendance / admission (0=no, 1=yes)	First assessment of alcohol use in hospital (0=no, 1=yes)	ED attendance only (0=no, 1=yes)
1. Age	-.17*	-.21**	-.22**	.03	-.19*
2. AUD severity (AUDIT score)	.15	.30**	.17*	-.26**	-.00
3. Past 6-month average alcohol consumption (AUDIT C score)	-.14	.04	.08	-.08	-.00
4. Psychological dependence (LDQ score)	.25**	.38**	.17*	-.34**	.05
5. Past week HDDs	.12	.17	.12	-.11	.03
6. Past-week unit consumption	.22*	.30**	.27**	-.27**	.07
7. Problem Perception (SOCRATES subscale)	.31**	.51**	.26**	-.18*	-.08
8. Taking Action (SOCRATES subscale)	.10	.09	.10	-.01	-.30**

Variable	In alcohol treatment at baseline (0=no, 1=yes)	Treatment access during 6-month follow-up period (0=no, 1=yes)	Direct alcohol-related attendance / admission (0=no, 1=yes)	First assessment of alcohol use in hospital (0=no, 1=yes)	ED attendance only (0=no, 1=yes)
9. Self-efficacy	.01	.20*	-.00	.09	-.07
10. Depression symptoms (HADS subscale)	.17*	.32**	.19*	-.29**	.16
11. Anxiety symptoms (HADS subscale)	.13	.21*	.11	-.18*	.12

*$p<.05$, **$p<.01$

NB: A coefficient with a negative sign indicates that the group with the highest coding has the lowest mean ranking of the two groups in terms of the continuous variable. A coefficient with a positive sign indicates that the group with the highest coding has the highest mean ranking of the two groups in terms of the continuous variable.

Appendix R

Table 4: Associations between binary variables measured at baseline (X^2), n=141

	1	2	3	4	5	6	7	8	9	10	11	12
1. Male gender	–											
2. Living with others	0.01 (.01)	–										
3. In a relationship	0.67 (.07)	50.31** (.60)	–									
4. Employed/in education	1.52 (.10)	2.07 (.12)	0.14 (.03)	–								
5. Current smoker	0.03 (-.01)	2.89 (-.14)	8.61** (-.25)	0.09 (-.03)	–							
6. Current use of illicit substances	0.12 (.03)	2.80 (-.14)	1.84 (-.11)	0.04 (.01)	4.78* (.18)	–						
7. Familial alcohol use disorder	.00 (.00)	.15 (.03)	1.08 (-.09)	.91 (.08)	.00 (.00)	6.86* (.22)	–					
8. In alcohol treatment at baseline	0.47 (-.06)	0.69 (-.07)	0.42 (-.05)	0.08 (-.02)	0.12 (.03)	4.88* (.19)	.31 (.05)	–				
9. Treatment access during 6-month follow-up period	0.47 (.06)	0.01 (.01)	0.38 (-.06)	0.08 (-.03)	0.90 (.09)	0.19 (-.04)	.79 (-.08)	17.70** (.38)	–			
10. Direct alcohol-related hospital attendance / admission	2.73 (.14)	1.25 (.09)	0.27 (.03)	0.01 (.00)	2.12 (.12)	1.28 (.10)	1.84 (.17)	2.17 (.12)	4.89* (.20)	–		

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	1	2	3	4	5	6	7	8	9	10	11	12
11. First assessment of alcohol use in hospital	4.34* (-.18)	0.15 (-.03)	1.02 (.09)	0.10 (-.03)	6.86** (-.22)	4.87* (-.19)	2.21 (-.12)	9.63** (-.26)	10.05** (-.29)	5.01* (-.19)	–	
12. ED attendance only	0.07 (.02)	0.43 (-.06)	1.34 (-.10)	0.46 (.06)	0.01 (.00)	1.57 (.11)	.93 (-.08)	0.61 (.07)	0.97 (-.09)	0.11 (.03)	0.15 (-.03)	–

X^2(φ). *p<.05, **p<.01

Appendix S   Comparison of participants lost to follow-up and those followed-up at six months

Table 1: Comparison of observed (n=121) and incomplete (n=20) cases at 6-months

Demographic Variable	Followed-up n=121 n (%)	Lost to follow-up n=20 n (%)	Statistical test	p
Gender				
Male	82 (67.8)	18 (90.0)	X^2 = 4.11	p = .043
Female	39 (32.2)	2 (10.0)		
Age				
18 – 24	6 (5.0)	1 (5.0)		
25 – 34	9 (7.4)	2 (10.0)		
35 – 44	22 (18.2)	3 (15.0)	X^2 = 2.16	p = .769
45 – 54	29 (24.0)	6 (30.0)		
55 – 64	34 (28.1)	3 (15.0)		
65+	21 (17.4)	5 (25.0)		
Marital Status				
Single	53 (43.8)	13 (65.0)		
Married / In a relationship	28 (23.1)	6 (30.0)	X^2 = 6.65	p = .062
Separated / Divorced	36 (29.8)	1 (5.0)		
Widowed	4 (3.3)	0 (0.0)		
Living Situation				
Living alone	62 (51.2)	10 (50.0)		
Living with child(ren)	3 (2.5)	0 (0.0)		
Living with partner	17 (14.0)	4 (20.0)	X^2 = 1.09	p = .897
Living with partner and child(ren)	10 (8.3)	2 (10.0)		
Other	29 (24.0)	4 (20.0)		

Employment status				
Employee/self-employed	18 (14.9)	3 (15.0)		
Away from work	8 (6.6)	0 (0.0)		
Sick/disables	55 (45.5)	11 (55.0)	$X^2 = 2.75$	$p = .764$
Unemployed	14 (11.6)	1 (5.0)		
Retired	23 (19.0)	4 (20.0)		
Other	3 (2.5)	1 (5.0)		
Smoking status				
Smoker	75 (62.0)	13 (65.0)	$X^2 = .07$	$p = .796$
Non-smoker	46 (38.0)	7 (35.0)		
Use of other substances				
Yes	20 (16.5)	3 (15.0)	$X^2 = .03$	$p = 1.00$
No	101 (83.5)	17 (85.0)		
Alcohol-related Variable	**Followed-up n=121** **n (%)**	**Lost to follow-up** **n=20** **n (%)**	**Statistical test**	***p***
Total past-week unit consumption (median)	108.0	126.0	$U = 1175.0$ $z = -.207$	$p = .836$
Number of past-week drinking days (median)	7	7	$U = 1112.0$ $z = -.696$	$p = .487$
Number of past-week heavy drinking days (median)	7	7	$U = 1162.0$ $z = -.322$	$p = .748$
Total AUDIT score				
8 – 15	3 (2.5)	1 (5.0)		
16 – 19	11 (9.1)	1 (5.0)	$X^2 = .73$	$p = .668$
20+	107 (88.4)	18 (90.0)		

LDQ score	Followed-up n=121 n (%)	Lost to follow-up n=20 n (%)	Statistical test	p
0	2 (1.7)	0 (0.0)		
1 – 10	35 (28.9)	4 (20.0)	$X^2 = 1.40$	$p = .694$
11 – 20	21 (17.4)	5 (25.0)		
21 – 30	63 (52.1)	11 (55.0)		
Other Variables of interest	**Followed-up n=121 n (%)**	**Lost to follow-up n=20 n (%)**	**Statistical test**	***p***
Referral source				
Alcohol Care Team	76 (62.8)	12 (60.0)		
VAST (Emergency Department)	36 (29.8)	8 (40.0)	$X^2 = 2.09$	$p = .695$
Psychological Medicine Team	7 (5.8)	0 (0.0)		
Other	2 (1.7)	0 (0.0)		
Assessment of alcohol use in hospital				
First assessment	52 (43.0)	8 (40.0)	$X^2 = .06$	$p = .083$
History of prior assessments	69 (57.0)	12 (60.0)		
Clear alcohol-related hospital admission				
Yes	91 (75.2)	12 (60.0)	$X^2 = 2.02$	$p = .156$
No	30 (24.3)	8 (40.0)		
Any previous alcohol support				
Yes	79 (65.3)	11 (55.0)	$X^2 = .79$	$p = .375$
No	42 (34.7)	9 (45.0)		
Depression symptoms (median HADS score)				
0 – 7	50 (41.3)	8 (40.0)		
8 – 10	16 (13.2)	3 (15.0)	$X^2 = .05$	$p = 1.00$
11 – 21	55 (45.5)	9 (45.0)		
Anxiety symptoms (median HADS score)				
0 – 7	39 (32.2)	5 (25.0)		
8 – 10	11 (9.1)	2 (10.0)	$X^2 = .42$	$p = .760$
11 – 21	71 (58.7)	13 (65.0)		

Appendix T   Hospital qualitative study participant characteristics

Pseudonym	Gender	Age group	Length of stay (days)	Direct alcohol-related admission?	First assessment of alcohol use in hospital?	Pre-hospital	Post-hospital	Heavy drinking days†	Psychological dependence††
			Details of hospital attendance/admission			**Specialist alcohol treatment engagement***		**Quantitative outcome at six months**	
Barbara	F	55 – 64	4	Yes	No	6 – 12 months ago	Last month	Unfavourable	Unfavourable
Luke	M	55 – 64	17	No	No	Last month	Last month	Favourable	Remained low
Howard	M	45 – 54	6	Yes	No	1 – 6 months ago	Last month	Favourable	Favourable
Marie	F	55 – 64	7	Yes	Yes	None	None	Unfavourable	Unfavourable
Milo	M	55 – 64	0	Yes	No	Last month	Last month	Favourable	Unfavourable
Robert	M	65+	26	Yes	No	None	None	Unfavourable	Favourable
Glen	M	55 – 64	7	Yes	Yes	None	None	Unfavourable	Remained low

Appendix T

Pseudonym	Gender	Age group	Details of hospital attendance/admission			Specialist alcohol treatment engagement*		Quantitative outcome at six months	
			Length of stay (days)	Direct alcohol-related admission?	First assessment of alcohol use in hospital?	Pre-hospital	Post-hospital	Heavy drinking days†	Psychological dependence††
Lynn	F	45 – 54	16	No	Yes	None	None	Favourable	Favourable
Graham	M	55 – 64	29	Yes	No	Last month	1 – 6 months ago	Favourable	Favourable
Lily	F	25 – 34	0	Yes	No	None	None	Unfavourable	Unfavourable
Gillian	F	65+	35	No	Yes	None	None	Unfavourable	Favourable
Daniel	M	35 – 44	2	Yes	No	1 – 6 months ago	Last month	Unfavourable	Favourable
Rick	M	45 – 54	4	Yes	Yes	None	1 – 6 months ago	Unfavourable	Favourable
Lee	M	45 – 54	0	Yes	No	6 – 12 months ago	None	Favourable	Unfavourable
Clive	M	55 – 64	0	No	No	1 – 6 months ago	None	Unfavourable	Favourable
Len	M	55 – 64	16	Yes	Yes	12+ months ago	None	Favourable	Favourable
Jack	M	45 – 54	10	Yes	No	Last month	Last month	Unfavourable	Unfavourable

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Pseudonym	Gender	Age group	Details of hospital attendance/admission			Specialist alcohol treatment engagement*		Quantitative outcome at six months	
			Length of stay (days)	Direct alcohol-related admission?	First assessment of alcohol use in hospital?	Pre-hospital	Post-hospital	Heavy drinking days†	Psychological dependence††
Simon	M	55 – 64	20	Yes	No	None	None	Unfavourable	Favourable
Steve	M	55 – 64	5	Yes	No	None	1 – 6 months ago	Favourable	Remained low
Trevor	M	55 – 64	3	Yes	No	Last month	1 – 6 months ago	Unfavourable	Unfavourable
Lorna	F	18 – 24	4	Yes	Yes	None	1 – 6 months ago	Favourable	Favourable
Joe	M	35 – 44	2	Yes	No	Last month	Last month	Unfavourable	Unfavourable
Donna	F	55 – 64	1	Yes	No	1 – 6 months ago	1 – 6 months ago	Favourable	Favourable
James	M	45 – 54	6	Yes	No	12+ months ago	None	Favourable	Remained low
Nathan	M	45 – 54	8	Yes	No	1 – 6 months ago	Last month	Favourable	Favourable
Aaron	M	35 – 44	0	Yes	No	Last month	None	Unfavourable	Unfavourable

Appendix T

* Defined as attendance at a community/residential alcohol treatment service or alcohol-specific mutual aid group

† **Favourable:** zero heavy drinking days at follow-up

    Unfavourable: ≥1 heavy drinking days at follow-up

†† **Favourable:** clinically significant change in dependence

    Unfavourable: no change or worse

    Remain low: stayed below threshold for clinically significant change

ACCOMPANYING DOCUMENTS

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Article

Internet Support for Dealing with Problematic Alcohol Use: A Survey of the *Soberistas* Online Community

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Abstract

Aims: Advances in technology have led to an increased range of possibilities for forms of mutual aid in addictions, and patient empowerment in the management of long-term conditions. However, the effective processes involved may be different online than for those that meet in person. *Soberistas* is a 'social network site for people who are trying to resolve their problematic drinking patterns'. We aim to describe the population, component parts and processes that define this online community, and consider potential mechanisms of action for future research.

Methods: Cross-sectional online survey through an advert embedded within the *Soberistas* website. Participants were asked questions about themselves, their alcohol use and use of the website.

Results: Four hundred and thirty-eight people completed the survey, primarily women, 50% of whom lived with their children. Over 60% described having problematic alcohol use for over 10 years and 46.5% had not tried any form of previous support. Participants accessed the site at different stages of change; over half still drinking alcohol, cutting down or recently stopped. Over 18% reported abstinence of over 1 year. Anonymity, the ability to be honest, being a source of trusted information, and ongoing support were all cited as reasons for continued membership.

Conclusion: *Soberistas* offers a form of mutual aid primarily for women who have often not engaged with other treatment or support. This preliminary study suggests that the online, flexible, platform affords members an accessible and anonymous community to address their difficulties and encourages a positive 'alcohol free' identity.

Short Summary: *Soberistas* is 'an online community of people who are trying to resolve their problematic drinking patterns'. Preliminary data suggest that it offers a flexible platform for mutual aid primarily for women who have often not engaged with other treatment or support, by encouraging a positive 'alcohol free' identity.

INTRODUCTION

Research into online groups and social networking sites for the management of a variety of health conditions suggests the positive role these groups play in offering support in a way that might not be available in traditional treatment services, in addition to the convenience and anonymity offered by a virtual meeting place (e.g. Greene *et al.*, 2011; Jones *et al.*, 2011; Christie, 2013; Stewart-Loane and D'Alessandro, 2013; Chung, 2014; Lockhart *et al.*, 2014; Stewart-Loane *et al.*, 2014).

The stigma attached to alcohol use disorders (AUD) results in lower levels of disclosure about alcohol use and acts as a barrier to seeking treatment (Jones *et al.*, 2015; Probst *et al.*, 2015), especially in treatment-naive people who may be uncertain how to construe their difficulties, and whether and where to seek appropriate help

(Schuler *et al.*, 2015). With advances in technology, there are increased possibilities with the Internet, and other forms of social media for people with AUD to seek help (Cunningham *et al.*, 2009; Hester *et al.*, 2013). This allows those who are unwilling or unable to go to in-person services to access support (Vernon, 2010; Hester *et al.*, 2013) and may also facilitate longer term self-management by people with AUD in a similar way to other long-term conditions (McKay and Hiller-Sturmhöfel, 2011).

There is now substantial evidence of the effectiveness of online interventions to reduce alcohol use in a range of increased risk drinkers drawing on Cognitive Behavioural Therapy and Self-Management and Recovery Training (SMART) principles (see White *et al.*, 2010; Riper *et al.*, 2011; Hester *et al.*, 2013, Riper *et al.*, 2014). However, there is limited addiction-specific research exploring the use of online groups that are underpinned by mutual aid and social support; the few studies that have considered online support groups (e.g. Humphreys and Klaw, 2001; Cunningham *et al.*, 2008; Coulson, 2014) agree that the Internet plays a crucial role in overcoming some of the physical and emotional barriers to accessing in-person support. Sharing success stories, helpful strategies and discussion of difficulties (Cunningham *et al.*, 2008), and disclosure of personal information, offering support and advice, and a shared goal of sobriety (Coulson, 2014) were identified as factors engaging people with online support. In a review of self-help groups more broadly, social support was found to be one of the 'key ingredients' (Moos, 2008), along with goal direction, structure, abstinence-oriented norms and role models. However, most of this research was within the 12-step community in the USA; there is still much to learn about the processes involved in online compared with in-person support.

The pace of change in the technology of social media and the increased expectations of those who use them provide a challenge to those designing platforms that optimise engagement and retention within online communities. But a review of mechanisms by which social media may have its effects in the self-management of chronic conditions considered this in terms of 'Affordance Theory' (Merolli *et al.*, 2013), i.e. when people interact with social media it is because of what they perceive it 'affords' them, concluding that the specific features and functionality of a social network platform are secondary to what they *afford* participants in terms of social interactions, information sharing, flexibility of access, more personalised support and an opportunity to share narratives (Merolli *et al.*, 2013).

The aim of this paper is to describe the population, component parts of a new peer-led online support group, 'Soberistas', and consider what the different parts of the site affords the members and browsers who use it, both as a form of mutual aid, but also to consider factors involved in designing an effective online platform for social support. Soberistas is a 'social network site for people who are trying to resolve their problematic drinking patterns' (Rocca, 2016). It was launched in 2013 by Lucy Rocca, 18 months after she became abstinent from alcohol, based on what she reflected had been her own needs at that time. The ethos is described as 'non-prescriptive, non-religious, and non-judgmental'. This is the first study to survey the membership and to consider its place in online support, as well as to generate hypotheses about mechanism of action of such sites for future research.

MATERIALS AND METHODS

A cross-sectional survey was designed comprising free text and fixed response questions, divided into four sections:

(1) *Demographics*
(2) *Soberistas membership*—Participants were either 'browsers' or 'members'. Browsers have access to most content, but cannot contribute to discussions; subscription-paying members have access to all areas of the site and full functionality. Participants were asked their reasons for joining and continued use, how participants became aware of the website, use of previous support (e.g. Alcoholics Anonymous (AA), SMART, none).
(3) *Soberistas usage*—Time spent on the site, which parts of the site do participants find most helpful and use most often. The website has five core features:
   (a) *Personal stories*—described as 'optimistic and honest accounts of how we managed to get our lives back on track by ditching alcohol, … to help others who are looking for a way out of the booze trap'. These are submitted by members, can be viewed by anyone.
   (b) Various *blogs and forums*—these include lifestyle articles written by the founder and editor of the website, as well as posts written by members, which are available to all, and a discussion forum on a range of themes (e.g. from campaigning to how to beat cravings) which can only be contributed to by members.
   (c) *Ask the Doctor* page—members are able to submit questions and view all responses which are replied to monthly.
   (d) *Webinars*—given by a range of experts in health, lifestyle, etc., only available to members.
   (e) *Chat room*—offering support and discussion threads in real time, for members only. In addition, there are also sections which feature alcohol-related news stories, signposting to other resources, adverts for books and therapies, and features such as a 'member of the month' and a book club.
(4) *Alcohol consumption*—Estimated length of problematic use, current/recent alcohol use and the impact of alcohol on five domains (physical health, mental health, close relationships, work/study and finances) using a six-point Likert scale. We also asked how consumption had changed since using *Soberistas*.

The survey took ~5 min to complete. It was piloted by 10 users of *Soberistas*, and minor adjustments were made following feedback about usability. *Soberistas* staff also reviewed and piloted the questionnaire but were not otherwise involved in its development, or the analysis of results. The study received a favourable ethical opinion (ERGO number 16245) and an invitation to participate in the survey was posted on the *Soberistas* website for 1 month.

Data from the online survey were imported directly into SPSS (SPSS Inc, 2015). Simple descriptive, and non-parametric statistics were used to analyse the numerical data and free-text responses were coded and categorised by S.C. and uncertainties discussed within the research team.

RESULTS

Overview

At the time of the survey (August 2015), there were 32,550 registered users (all who had registered since the site was launched in 2013). Of these, there were ~3800 active users; 1828 were subscription-paying members and ~2000 active browsers.

Of the 1828 members and 2000 browsers, 438 participants (11.4%) completed the online survey, but 6 participants did not complete any of the alcohol data questions and so these were

excluded from the analysis. The demographics of the sample are shown in Table 1.

Of those who completed the survey, 280 (64.8%) were fee paying members and 150 (34.7%) were browsers. As can be seen from Table 1, the vast majority of survey responders were white females, based in the UK. Half were living with children, either alone or with a partner, 73.4% were employed and only 1.5% ($N = 5$) describing themselves as long-term sick or disabled. Almost 70% had some form of post school-leaving qualification and 27.5% describing themselves as having a higher (postgraduate) degree.

A comparison of fee paying members with browsers showed that members were more likely to report being <1 year sober (86.4% vs 73.8%; X^2 10.5; $P = 0.001$), but there was no difference as to whether they had sought help from any other source previously (64.3% vs 66.0%; X^2 0.129; $P = 0.720$) or reported having an alcohol problem for >10 years (67.7% vs 61.0%; X^2 1.95; $P = 0.163$).

Alcohol history

Information related to participants' reported alcohol use and access to previous support is shown in Table 2. Over 60% of participants rated themselves as having had problematic alcohol use for over 10 years (the longest response category available) and another 28.9% acknowledging problematic use for between 3 and 10 years. Almost half (46.5%) had not accessed any previous support, 28.9% had tried AA and <20% had asked or received help from a healthcare professional or service. Of those who had previously sought help, there was no difference in reported length of alcohol problem; 56.5% (>10 years) vs 49.1% (<10 years), X^2 2.24; $P = 0.134$.

Participants had clearly joined the website at different stages of their change in alcohol use; 10.3% had joined the site already abstinent, looking for support in remaining so; 34.3% described themselves as becoming 'alcohol free' since joining the site; 23.8% described themselves as having reduced their alcohol consumption and 12.5% with no change in their drinking behaviour.

Those who reported sobriety of longer than 1 year were more likely to have sought some form of help previously (21.7% vs 13.5%, X^2 4.9; $P = 0.026$), and if they were fee paying members,

Table 1. Demographics of survey responders ($n = 432$)

Variable	n (%)
Gender	
Female	404 (94)
Age (years)	
18–24	3 (0.7)
25–34	16 (3.7)
35–44	112 (25.9)
45–54	181 (41.9)
55–64	89 (20.6)
64+	31 (7.2)
Ethnicity	
Caucasian	419 (97)
IP address location	
UK	311 (71.9)
USA	56 (12.9)
Australia	9 (2.1)
Canada	9 (2.1)
Other	47 (10.8)
Household composition	
Lives alone	58 (13.4)
Lives with child(ren)	46 (10.6)
Lives with partner	141 (32.6)
Lives with partner and child(ren)	170 (39.4)
Other	16 (3.7)
Missing	1 (0.2)
Occupation	
Employed	317 (73.4)
Of which self-employed	104 (24.1)
Retired	41 (9.5)
Homemakers	45 (10.4)
Other[a]	27 (6.3)
Missing	2 (0.5)
Highest qualification	
Postgraduate degree	119 (27.5)
Bachelor's degree	142 (32.9)
School leaving	88 (20.4)
Further training qualification	38 (8.8)
None	17 (4)
Other	27 (6.3)
Missing	1 (0.2)

[a]Other includes student, long-term sick/disabled, maternity leave, etc.

Table 2. Alcohol use and previous support ($n = 432$)

Variable	n (%)
Length of problematic alcohol use	
<1 year	13 (3)
1–3 years	22 (5)
3–10 years	125 (28.9)
10+ years	270 (62.5)
Missing	2 (0.5)
Previous support tried	
AA	125 (28.9)
SMART recovery	29 (5.8)
Other online	50 (11.6)
Healthcare	83 (19.2)
Other[a]	72 (16.7)
None	201 (46.5)
Last drink of alcohol	
Within 24 h	108 (25)
Between 1 and 7 days	77 (17.8)
>7 days <1 month	43 (10)
>1 month <6 months	87 (20.1)
>6 months <1 year	38 (8.8)
Over a year ago	77 (17.8)
Missing	2 (0.5)
Units consumed in the previous 7 days	
0	238 (55.1)
1–35	111 (25.7)
36+	78 (18.1)
Missing	5 (1.2)
Change in alcohol consumption since joining[b]	
No change (still drinking)	54 (12.5)
Now alcohol free	148 (34.3)
Maintained abstinence	47 (10.9)
Reduced consumption	103 (23.8)
Other[c]	79 (18.3)
Missing	1 (0.2)

[a]Other includes alternative therapies (e.g. hypnosis), private counselling, inpatient rehabilitation.
[b]Based on categorisation of free-text responses.
[c]Other examples: 'more aware of the problem', 'too new [to the site]' or just said 'yes'.

were more likely to have joined over a year ago (27.0% vs 9.4%, X^2 12.8; $P = 0.001$).

Impact of alcohol on various domains

All participants 52.7% ($N = 228$) who admitted to drinking alcohol in the last month were asked to rate the impact of alcohol in the last month on each of the following domains: physical health, mental health, close relationships, work/study and finances; using a six-point Likert scale to answer five questions: 'In the last month, how much would you say your (e.g. physical health) has been affected by your alcohol consumption?' (see Fig. 1).

Mental health was most likely to be rated as being 'extremely' affected by current alcohol use 112/219 (51%), followed by physical health 75/220 (34%) in those who had drunk alcohol in the last month. Close relationships, work/study, and finances were less likely to be rated as being 'extremely' affected, but still were so by 26%, 26% and 24% of participants respectively. In terms of finance 97/216 (44.9%) of participants rated them 'not at all' affected by current alcohol use.

Website structure and use

All aspects of the website were listed, and participants asked to rate how often they used each section and how helpful they found it.

(1) *Personal stories*—these are submitted by members, can be viewed by anyone and were cited as 'particularly helpful' by 80.8%, and used sometimes/frequently by 91% of respondents.
(2) Various *blogs and forums*—which are available to all, and a discussion forum on a range of themes (e.g. from campaigning to how to beat cravings) which can only be contributed to by members. These areas were cited as 'particularly helpful' by 73.1%, and used sometimes/frequently by 82% of respondents.
(3) *Ask the Doctor* page—rated as 'particularly helpful' by 29.3%, and used sometimes/frequently by 59.6% of subscription-paying respondents.
(4) *Expert Webinars*—rated as 'particularly helpful' by 34.6%, and used sometimes/frequently by 61.8% of subscription-paying respondents.
(5) *Chat room*—rated as 'particularly helpful' by 19.6%, and used sometimes/frequently by 41.1% of subscription-paying respondents.

The majority of respondents (81%) spent between 1 and 3 h on the site, 13.9% spent between 4 and 10 h, and a 4.4% over 10 h on the site in the last week, and this was rated as 'usual' by 71.3%.

Reasons for browsing/joining the website

Responses to this free-text question were coded and summarised in Table 3. Each participant could list more than one reason.

As can be seen from Table 3, almost 65% of responses expressed some goal related to changing their relationship with alcohol. These ranged from people wishing to increase their awareness of the problem to those who had already stopped drinking but were looking for support to help maintain abstinence. Support from a peer group with similar experiences was cited by 30% for their use of the site, while 10.6% stated they were exploring alternative options or were unsure if they would be suitable for other formal or peer-group support. Hearing or reading about the site opportunistically and finding a resonance with it was mentioned by 14% of respondents.

For the 280 participants who were paid-up members of the site, the reasons why they continued varied (see Table 4). As well as the personal goals of attaining abstinence or remaining alcohol free, respondents also cited the importance of being part of a community, and wishing to give something back to the site either financially or by peer support to those still struggling. Respondents also appeared to value it as a repository of useful and interesting information, not only around alcohol but on health and well-being which are part of the *Soberistas* philosophy.

DISCUSSION

Although the survey was only completed by 15% of subscription-paying members and ~8% of browsers, the results give an indication of the users and processes of this online community. Most striking is that although almost two-thirds of the sample describe problematic alcohol use for over 10 years almost half had never tried any previous form of support. Of those still drinking, just over 50% describe the impact of alcohol on their mental health as being 'extremely severe'. Combined with their reports that almost half were living at home with children there may well be effects on the health and well-being of a family. Respondents were primarily female, overwhelmingly in
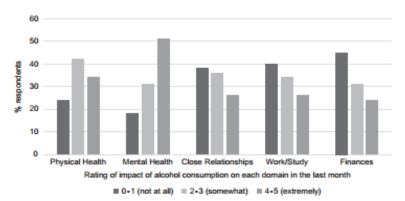

Fig. 1. Impact of alcohol on those still drinking over the previous month ($n = 228$).

Table 3. Categorisation of free-text data: reasons for joining (*n* = 432)

Categorised response	*n* (%)	Example responses
Alcohol-related goals	280 (64.8)	'To try and stop drinking alcohol.' 'To make me aware of how much I'm drinking.' 'Concern over alcohol consumption.' 'To help me stay sober.'
Support from others	130 (30.1)	'Love the camaraderie—and I think many women like myself.' 'Like minded support.' 'To have people who understand to communicate with. Advice.' 'I'd given up drinking 18 months previously, had moved and wanted a support network.'
Curiosity in the concept/alternative form of support	46 (10.6)	'I wanted to stop drinking and didn't want to go to AA.' 'I was looking for online support other than AA.' 'I felt it was very accepting and other forms of help available were stigmatising...I wasn't really sure if I was "bad" enough to need other alcohol services.' 'Soberistas seems strong, and I love the "normalization" of the problem.'
Media	61 (14.1)	'Read about it in a newspaper article then signed up.' 'An article of Lucy's in Good Housekeeping.' 'Heard about them on a Radio 4 programme.'
Other reasons, e.g. • Anonymity • Recommendation • Generic answers • Information	38 (8.8)	'My mum found this site and recommended it to me as it sounded just like my behaviour.' 'Self-awareness.' 'Good source of information.'

Table 4. Categorisation of free-text data: reasons for continuing membership of the site (*n* = 280)

Categorised response	*n* (%)	Example responses
Community support	151 (55.9)	'It's good to have ongoing support, and to feel part of a community, and that I am not alone and a "failure". Hearing about others struggling with this problem is helpful.' 'The sense of community with people who understand.' 'The help and friendships I've made.' 'Feel part of a family.'
Specific features of the site including information and advice	70 (25.9)	'Being able to view webinars.' 'I find the blogs and notes encouraging.' 'I like to read other people's stories.' 'Belonging to an organisation that gives excellent advice to those abusing alcohol.' 'Interesting articles.' 'Get a lot of benefit with a wide range of issues not just alcohol.'
Alcohol-related goals	54 (20)	'I will be sober 6 months in a week. Could not have done it without Soberistas and need Soberistas every day.' 'To remind me why I stopped drinking.' 'I don't think I would still be sober without the site.' 'I don't want to relapse.' 'Want to stop drinking.' 'I am still worried about my drinking.'
Wishing to give back (to the site as a whole, and to other members)	18 (6.7)	'To support the site, and because it helped me so much.' 'Being able to contribute financially so that the site continues to be available for those that need it.' 'To be able to help others.'
Other; e.g. • General interest • Curiosity • Cost • Generic comments • Convenience	43 (15.9)	'Interest in the subject.' 'The membership fee is affordable.' 'Direct debit! Only look occasionally now.' 'Knowing it's in the background.' 'Being able to drop in as I wish.'
Will not be continuing	12 (4.4)	'I won't be continuing it.' 'Not sure I will.'

employment and with postgraduate qualifications. This resonates with findings from the US-based 'Moderation Management' (MM), an online platform for non-dependent drinkers (Humphreys and Klaw, 2001). Those who used MM only were significantly more likely to be female and have greater severity of AUD than those attending in-person meetings, and those with any online MM contact had higher levels of education. As with our study, the authors argued that online MM tapped into a specific group within the population who might

otherwise not access alcohol-related services, and for whom the convenience and anonymity of online support networks are particularly beneficial.

Participants in our study describe coming to the site at various stages of change of their alcohol use, with 10% joining the site having already achieved abstinence. A similar number were still drinking but using the site for information and to explore what options were available to them, as well as to compare their situation with that of others. Stewart-Loane et al. (2013, 2014) studying online health platforms in general found that members with other chronic health conditions may alter their use of online communities over time depending on their needs—for example, at the start of membership their motivation may be to seek information, but as time passes and ongoing communication between other members enhances the value of the community, they start to create value for others by offering support or information, and so the design of the site, enabling people to make these transitions within a single platform without having to find a new site potentially breaking off helpful relationships, makes for 'affordance' (Merolli et al., 2013).

In their review, Merolli et al. (2013) suggested five categories that help to explore the underlying processes which may be involved for people joining virtual mutual aid groups, such as Soberistas; they termed these identity, flexibility, structure, narration and adaptation.

Identity and narration

People using condition-specific social media sites are afforded 'more choice and control over how they present and assert themselves' with features such as blogs and chat rooms allowing discussion of taboo or difficult topics more honestly than they might face to face, especially for stigmatised conditions. This is likely to be particularly important at the beginning of engagement with a site. Soberistas participants valued being able to read 'personal stories' of people they identified with, responding to posts and using blogs and forums.

Flexibility

AA has frequent meetings in many geographic locations such that an individual can regulate how many meetings they attend based on their own needs. An online community facilitates a similar self-regulation of need by being constantly available. The review suggested that 'asynchronous' communication (i.e. people being able to post comments at any time, and are not required to reply immediately, unlike chat rooms, or face-to-face meetings) may aid rather than hinder communication and enable people to engage with topics and emotions when they feel ready to do so. The literature for people with addictions and problematic drinking (Finn, 1996; Humphreys and Klaw, 2001; Cooper, 2004) suggests that the convenience of an online platform is helpful for some, and in this study, the range of time spent on the site (from <1 h to over 10 in the last week) suggests flexibility is important. However, the role of asynchronous communication as a facilitator for social support is something that requires further exploration.

Structure and adaptation

This refers to the 'architecture of participation'—the different levels at which people connect with each other, share relevant information and facilitate self-management. This requires a range of functions (blogs, webinars, chat rooms, etc.) within the one site so as to enable participants to flexibly navigate between them according to their needs. In our study, participants reported different patterns of use of the site, which may be based on their stage of change and needs over time, and fits with findings of online supportive communities for other disorders (Stewart-Loane and D'Alessandro, 2013; Chung, 2014; Stewart-Loane et al., 2014).

Respondents to the Soberistas survey made reference, via free-text comments (see Tables 3 and 4), to a variety of social support behaviours enacted on the site, and this was a commonly cited reason for spending time on the site, and continued membership. Recent work describing a Social Identity Model of Cessation Maintenance (SIMCM, Frings and Albery, 2015) and a Social Identity Model of Recovery (SIMOR, Best et al., 2016) highlights the importance of social identity processes in recovery; the authors argue that connection to recovery-orientated groups helps facilitate the development of a non-drinking social identity necessary for sustained recovery (although SIMCM takes a social cognitive perspective while SIMOR views social identity transitions within a changing social context from a systemic, rather than an individual, perspective). Both these models have relevance for how individuals engage with online peer-led communities, but in-depth empirical research is required to elucidate this further, including further qualitative work around the role of identity in the recovery process.

Community surveys have long shown that many people with alcohol-related problems can resolve these without formal treatment and those who make it into treatment services are often at the more severe end of the spectrum with a trajectory of a chronic relapsing and remitting illness. A recent review (White et al., 2012) suggests that the ability to resolve alcohol problems depends on an interaction between different levels of personal vulnerability, severity, as well as individual and community recovery capital. At present, it is not possible to say whether the members and browsers of the Soberistas website belong to a group who would have a high percentage of natural resolution, due to higher levels of social capital (Granfield and Cloud, 2001), or whether it offers an earlier intervention to people before they reach the stage of a more severe, chronic and relapsing condition with the associated loss of their protective factors of work and family. However, given that the majority in this study describe long-standing problematic use, and around half had sought other forms of assistance, with those who reported sobriety of longer than a year more likely to have sort help previously, it may be that Soberistas is offering this group something different than that previously available within the treatment system.

The results are limited by the relatively small sample size, the cross-sectional nature of the survey and the inability to validate the veracity of any online responses. However, they do suggest that the site provides a supportive online environment to a group which has not successfully engaged with treatment or other forms of peer support. As technological advances make online social support increasingly accessible, the opportunity to develop effective peer support online will require an understanding of the needs of specific groups, in terms of models of social support, but equally how best to engage specific populations and retain participation in online communities, as well as developing appropriate research methods to capture this interaction.

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CONFLICT OF INTEREST STATEMENT

Between January 2014 and July 2016, J.S. responded to 'Ask the doctor' questions monthly on *Soberistas* (unpaid). The other authors declare no conflicts of interest.

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Identity in recovery from problematic alcohol use: A qualitative study of online mutual aid

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ABSTRACT

Aim: To explore how engagement with online mutual aid facilitates recovery from problematic alcohol use, focusing on identity construction processes.
Design: Qualitative in-depth interview study of a maximum variation sample.
Setting: Telephone interviews with UK-based users of Soberistas, an online mutual aid group for people who are trying to resolve their problematic alcohol use.
Participants: Thirty-one members, ex-members and browsers of Soberistas (25 women, 6 men): seven currently drinking, the remainder with varying lengths of sobriety (two weeks to five years).
Findings: Three key stages of engagement were identified: 1) 'Lurking' tended to occur early in participants' recovery journeys, where they were keen to maintain a degree of secrecy about their problematic alcohol use, but desired support from likeminded people. 2) Actively 'participating' on the site and creating accountability with other members often reflected an offline commitment to make changes in drinking behaviour. 3) 'Leading' was typically reserved for those securely alcohol-free and demonstrated a long-standing commitment to Soberistas; leaders described a sense of duty to give back to newer members in early recovery and many reported an authentic identity, defined by honesty, both on- and off-line.
Conclusions: Engagement with online mutual aid might support recovery by affording users the opportunity to construct and adjust their identities in relation to their problematic alcohol use; individuals can use the parameters of being online to protect their identity, but also as a mechanism to change and consolidate their offline alcohol-related identity.

1. Introduction

Recovery is often conceptualised as a journey involving a complete life change (Laudet, 2007) that may include a transformation of identity into a 'non-drinker/user' (e.g., Biernacki, 1986; Buckingham et al., 2013; Doukas, 2011; Hill and Leeming, 2014; Reith and Dobbie, 2012). Change in social networks and engagement with recovery-orientated mutual aid groups (e.g., Alcoholics Anonymous, AA) may facilitate this transformation by encouraging development of a strong recovery-based social identity (Best et al., 2015; Frings and Albery, 2015). Social Identity Theory (SIT) contends that individuals establish their sense of self by drawing on their membership to social groups (Tajfel and Turner, 1979);

mutual aid groups, which rely on people with similar experiences helping each other through provision of social, emotional, and informational support (Public Health England, 2013; Raistrick et al., 2006), can provide members with a clear normative structure from which to derive their identity, values, and goals (Moos, 2008). Research has sought to understand the effectiveness of mutual aid (particularly within AA), but the underpinning mechanisms remain unclear.

Online groups have become popular for anonymous support and information (Dosani et al., 2014; Humphreys and Klaw, 2001), and can circumvent barriers to in-person meetings or services, including stigma, embarrassment, and inaccessibility (Cunningham et al., 2011; Gunn, 2015; Khadjesari et al., 2015). Online networks afford users a flexible platform to share narratives within a discreet environment (Merolli et al., 2013), which may be particularly beneficial for stigmatised groups (Hurley et al., 2007).

Users of online groups can disclose information at their own pace (Cooper, 2004), and selectively self-present (Walther, 1996);

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this permits the construction of an identity/identities that exist alongside others in the 'real world'. Tracy and Trethewey's (2005) 'crystallised self' theory conceptualises identity as multidimensional, fluid and context-dependent: there is no 'fake' nor 'real' self, just different aspects of the whole. This theory, stemming from a social interactionist view of identity (Blumer, 1969; Goffman, 1959; Mead, 1934) holds that one's self is constructed through social interactions; it is not static, but changes and develops as a function of social context and audience. The use of the internet is therefore interesting for identity construction because as McEwan and Mease (2013) note, the relationship between physical self (e.g., age, gender, race), location (e.g., home, work) and audience – all provide information about membership to identity groups and determine which identity is enacted – is "altered" (p.87–88).

Research on identity around self-harm (Adams et al., 2005), eating disorders (Gavin et al., 2008), and gambling (Cooper, 2004) through internet sites is growing, but little is known about identity for problematic alcohol use[1] in online groups, and a recent review called for more qualitative research to understand alternatives to the 12-step approach (Parkman et al., 2015). Soberistas is an online mutual aid group, described by its founder as 'non-prescriptive, non-religious, and non-judgemental' (Rocca, 2016) and entirely peer-led except for limited content moderation. It is a private limited by shares company and a social business with a global membership base (including the UK, USA, and Australia) of 1828 subscription-paying members (fee: £34/year) and ~2000 active browsers. Subscription-paying members can create a profile, engage in discussions, post blogs, watch webinars and utilise various information resources; browsers can view most content but with restricted usage. A recent survey of the Soberistas community (Sinclair et al., 2016) found 94% of respondents to be female, the majority aged between 45 and 55 years, and 50% living with children. Over 60% reported problematic alcohol use for more than 10 years, although 46.5% had not utilised any form of support previously. While Sinclair et al. (2016) reported an evaluation of the Soberistas community, including description of its members and component parts and processes, the aim of the present paper is to explore how engagement with this online mutual aid group might facilitate recovery from problematic alcohol use, focusing on identity construction processes.

2. Methods

SEC conducted 31 in-depth telephone interviews with Soberistas users between October 2015 and January 2016. Participants were recruited via an online survey embedded within the Soberistas website (Sinclair et al., 2016); respondents provided an email address if willing to discuss their views and experiences of using the site. To be eligible, participants had to be over 18 years, based in the UK, speak English, visited Soberistas at least once and have telephone access. Seventy-six people provided email addresses.

Our strategy was to achieve a maximum variation of characteristics expected to influence experience of the site (Patton, 1990), including age, gender, current levels of alcohol use, previous treatment history and length of time with Soberistas. Using information provided during the survey, we purposively sampled and contacted 58 people. To address gaps in the sample, we placed an advert on Soberistas specifically inviting males, those new to the site, or thinking of leaving, to participate. The final sample comprised current subscription-paying members, ex-members, and browsers, 28 of whom were recruited via the survey, and 3 via the advert (Table 1

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[1] The term 'problematic alcohol use' is used throughout this paper to reflect the words used by participants when describing a spectrum of harmful and dependent drinking patterns.

Table 1
Participant characteristics.

Characteristics	Participants n (%)
Gender	
Female	25 (80.6)
Male	6 (19.4)
Age	
25–34	2 (6.5)
35–44	7 (22.6)
45–54	8 (25.8)
55–64	10 (32.3)
65+	4 (12.9)
Membership status	
Current subscription-paying member	24 (77.4)
Ex-member	4 (12.9)
Browser (non-member)	3 (9.7)
Estimated length of time on the site	
<1 month	2 (6.5)
1–3 months	3 (9.7)
3–12 months	10 (32.3)
>12 months	16 (51.6)
Drinking Status	
Currently drinking	7 (22.6)
Alcohol-free ≤ 1 year	12 (38.7)
Alcohol-free > 1 year	12 (38.7)
Treatment/Support (other than Soberistas)	
None	13 (41.9)
Previous	13 (41.9)
Current	5 (16.1)

* Examples of 'treatment/support': AA, private counselling, community services, other online support, and inpatient rehabilitation.

shows participant characteristics). Some participants had found Soberistas weeks prior to interview, while others had used the site since its launch (November 2012). Of those alcohol-free at time of interview, length of sobriety ranged from two weeks to five years.

During interview, participants were asked to talk freely about their use of alcohol, treatment history, and their views, experience and use of Soberistas. Open-ended interviewing techniques encouraged participants to lead, but the researcher used probes, asking for clarification with specific examples where necessary. Later interviews became more focused, reflecting the decision of the authors to concentrate on a few key categories (see data analysis section below). Interviews lasted on average 48 min (range 19–121). Participants were offered a £10 Amazon e-voucher for their contribution.

All participants provided verbal informed consent at the start of interview. The University of Southampton Faculty of Medicine ethical review committee approved the study [ID:17030/18457].

2.1. Data analysis

Interviews were audio-recorded and transcribed verbatim by SEC. The qualitative software package NVivo (v.10) was employed to aid storage, retrieval, and systematic coding of data.

This study was informed by constructivist grounded theory methodology (Charmaz, 2014), which acknowledges and emphasises the role of researchers in constructing theory from interactions with participants, knowledge of the field through personal experience, and/or relevant literature. SEC led analysis with discussion and input from the research team. In accordance with principles of theoretical sampling, data collection, coding and analysis were conducted recursively: the decision about who was selected for interview and topics of interest in each interview were informed by analysis of prior data. Participants were selected if they were expected to increase understanding of the theory as it developed.

Analysis began with line-by-line open coding of transcripts from which the authors identified a variety of themes (Charmaz, 2014). After discussion amongst the team about theoretical plausibility of early ideas, a decision was made to focus on issues of identity once it became apparent this could be central to participants' experiences; subsequent focused coding and memo-writing allowed for refinement of key categories pertaining to identity. The constant comparative method (Glaser and Strauss, 1965) was used to generate labels for codes and themes identified within the data; constant comparisons were made between interviews, codes, and categories.

The main findings were sent to five individuals selected for their professional and/or personal experience within the addictions field. A focus group was conducted with three and written feedback received from two; the aim was to see whether results resonated with a broader stakeholder group and proved invaluable in improving the clarity with which findings were conceptualised and presented.

3. Results

We use participant quotations to demonstrate how our interpretations are grounded in the data, with identifier format as: gender-specific pseudonym, membership status, drinking status.

3.1. Searching for a common identity: 'lurking' on Soberistas

Upon finding Soberistas, most participants reported time spent 'lurking', that is, passively "consuming all the material" without actively contributing. Many read stories of likeminded people with similar backgrounds and experiences, and described a "resonance" with the site's ethos. 'Lurking' often provided reassurance:

"Reading other people's stories was so important because it made me realise I wasn't alone. . .to know that it wasn't unique to me, but there were people exactly like me. . .my age, my profession, my social background." (Angela, member, 2-months alcohol-free).

Many participants said it was a "relief" to find Soberistas because the secrecy that often surrounded their drinking resulted in them feeling "isolated", "trapped" or "lost". As Sarah explained:

"I had this hidden secret that I was a drinker. I presented myself to the world as efficient, a coper. . .there's the pride, the secretiveness of it, you're presenting one side, but in actual reality, that's not what you're really like" (Member, 3-months alcohol-free).

Several participants reported never telling anyone (including professionals) about their problematic alcohol use to protect their relationships, career, pride, or self-image. Many relied on the internet for information and advice about problematic drinking, and this was a common route to finding Soberistas.

Almost every participant spoke about the benefit of 'lurking' to access support anonymously, which was considered especially important during early recovery. Michelle explained:

"You want to keep a lid on it so much; you want to contain it yourself. . .it's a huge comfort that you're shrouded – there's no spotlight on your real life" (Member, 5-months alcohol-free).

Many participants described feeling ashamed about having an 'alcohol problem' and the fear of stigmatisation motivated them to keep their drinking hidden. 'Lurking' therefore afforded participants a safe way "to read and get information" (Dave, member, 1-year alcohol-free) from supportive people with similar experiences, yet preserve the secrecy that dominated this phase of recovery.

3.1.1. Understanding the Soberistas 'identity'.
Whilst 'lurking', participants assessed whether Soberistas could support their recovery journey; they explained that the site had a clear ethos characterised by specific language, values, norms, and beliefs. For example, Kevin explained:

"The first night I was on. . .the first message I got was, 'how long are you AF?' Well I didn't know what 'AF' was – I was actually too embarrassed to ask what 'AF' was. I kind of worked it out myself. . .I thought that must be 'alcohol-free'." (Member, 2-years alcohol-free)

Numerous participants spontaneously used the term 'alcohol-free' during interview which they explained was central to the Soberistas 'identity', being *"softer than saying ex-alcoholic"* (Louise, browser, 3-weeks alcohol-free). The term 'alcoholic' was considered by those who mentioned it to be derogatory, stigmatising and something with which they could not identify: *"I fundamentally did not, and still do not believe that I was 'an alcoholic'"* (Hayley, ex-member, 3-years alcohol-free). Consequently, participants often welcomed the *"softly, softly approach"* (Angela, member, 2-months alcohol-free) advocated on Soberistas; viewing the decision to give up alcohol as a "healthy lifestyle" choice helped many accept their problematic alcohol use without evoking shame. Abby explained:

"What I like [about Soberistas] is that it's not shaming. . .it just helped me to not feel really crap about myself because I could see that other people had this problem. . .other women with children and jobs. . .not necessarily down and outs." (Member, currently drinking)

Although participants described Soberistas as "friendly" and "welcoming", the site was said to unequivocally promote complete abstinence, and members were expected to endorse this alcohol-free identity online – Sarah explained that to fully integrate into the community she had to "earn [her] stripes" and equated this with being alcohol-free; she said, "I've been sober 88 days. . .I can justify being part of the group now" (Member, 3-months alcohol-free). Another participant explained the only requirement for joining was a "commitment and desire to be alcohol-free" and the concern if someone expressed contradictory opinions:

"There would be quite a big backlash and it's usually the newer people – the 'newbies' – that really don't understand what all the fuss is about. But it's about maintaining the ethos of the site and what it stands for." (Karen, member, 13-months alcohol-free)

While firm 'rules' around abstinence gave some participants the impetus to take their drinking seriously, others described feeling "intimidated" by members who advocated an abstinence-only approach, Liz explained:

"I said I was thinking of having a drink – I got lots of support but I also got lots of aggressive comments. Then when I did drink, I blogged about it, but it got really quite nasty. . .I stopped blogging." (Member, currently drinking)

Liz later stated she would not renew her membership because of "hostility" from others, and the site's inability to support her attempt to moderate drinking.

3.2. Creating an 'identity' through active participation

Several participants recalled the first time they contributed to Soberistas and moved from 'lurking' to actively 'participating'. For example, Linda recalled:

"I started tapping into the site and reading every so often, and then I thought, I've got to do something about this. . .I must have read on

the site for a few months before I ever did the first blog." (Member, 15-months alcohol-free).

Another participant, Michelle, wrote her first blog the day she stopped drinking. She explained why participating and 'creating an identity' on *Soberistas* helped her maintain abstinence:

> "Once you create an 'identity', and you put yourself out there on blogs or commenting on other people's blogs, you're almost a little bit, in your heart of hearts, accountable...there's almost, well I'm out there now...you're accountable to everybody." (Member, 5-months alcohol-free).

Alcohol-free members frequently discussed the importance of accountability in sustaining abstinence, and a mechanism for accountability is active engagement on the site. This was corroborated by participants who reported non-engagement and lack of accountability when drinking, for example:

> "When I was going through a moderating phase, I didn't really look at the site...I didn't really want to engage. Using the site is for me to not drink...when I am drinking I kind of don't see the point." (Kimberley, member, 2-months alcohol-free).

Establishing smaller, more personal communities within the larger *Soberistas* network was a common way of creating accountability. Participants explained that members often joined others with similar demographics (e.g., age), goals (e.g., 30-days alcohol-free) or interests (e.g., yoga), and this helped foster "mutual support" and "understanding", which often paved the way for "intimate" and "real" friendships on *Soberistas*, occasionally involving in-person meetings.

Engagement with likeminded people also provided alcohol-free participants with reaffirmation of their decision to remain so, despite possible resistance or lack of understanding from people offline:

> "It's a bit hard because they [friends/family] don't understand, but that's why I get solace in the website and from reading Lucy's [Soberistas' founder] book...because those are people, even though I've never met them, they can understand...no-one else understands why I've given up." (Maria, ex-member, 2-years alcohol-free)

Some participants cited lack of understanding and perceived stigma in their offline lives for confining expression of their difficulties with alcohol on *Soberistas*. Many wished to keep online and offline identities separate, and when this was jeopardised, some reported feeling fearful. For example, Kerry explained what happened when a friend joined *Soberistas*:

> "I went for a dinner party locally and a friend mentioned it [Soberistas]...I just ran home that night and deleted everything because I've got far too much personal information on there...it terrified me...I haven't blogged since." (Member, 3-months alcohol-free).

This fear of being recognised caused some participants to keep their offline identity hidden on *Soberistas*, and many discussed the benefits of doing so, namely the ability to "open up about things they wouldn't normally" (Tina, member, 1-month alcohol-free) – anonymity therefore encouraged personal disclosures, and was often considered helpful for recovery:

> "I just found it easier to talk about the whole subject anonymously...it becomes terribly easy to talk about it in a third person almost, as if you're somebody else, and I found that very helpful. I found it much easier to admit that I was sitting there at 9 o'clock in the morning with a bottle of vodka." (Ben, member, 3-years alcohol-free)

For many, the *Soberistas* community provided a rare opportunity to "offload" to people who understand – Angela explained that was "the kick-start behind making changes" (member, 2-months alcohol-free).

3.3. Modelling the 'Soberistas identity': leading the way

Some described a further engagement transition from 'participating' to 'leading'. Participants either self-identified as leaders, or referred to others in 'leadership' roles – for example, in discussing a small thread she was part of, Sarah described the group founder as their "mother hen" (Member, 3-months alcohol-free), and Linda, the leader of another group said, "When I started the discussion...I had progressed to being a grown-up [laughs]!" (Member, 15-months alcohol-free).

Participants explained members earned 'leadership' status through consistent online activity over time and continued abstinence, congruent with the *Soberistas* ethos. Attribution of leadership status was informal; essentially some members were "role models" (Sonia, member, 7-months alcohol-free), acting like "sponsors [as in AA] without the title" (Paul, member, currently drinking).

Those who considered themselves leaders described a sense of obligation "to give back to other people who are just starting out" (Michelle, member, 5-months alcohol-free), from which they too benefitted:

> "It's kept me more on the straight and narrow because I'm running this blooming discussion forum...no weakness allowed!" (Linda, member, 15-months alcohol-free).

Reduced anonymity online often accompanied leadership on *Soberistas*. Jenny, a self-professed leader said, "I thought I'm going to be open...known by my own name...and I was going to stand up and be counted for" (member, 5-years alcohol-free). Jenny explained she hoped by revealing her personal identity on *Soberistas*, others would follow. She considered it important to give a face "to this hidden group" and reduce stigma attached to problematic drinking.

3.4. "Secure in sobriety": arriving at an 'authentic identity'

Several participants, mostly leaders or those with longer periods of abstinence, described being "secure in sobriety" (Caroline, member, 3-years alcohol-free). This marked a significant change, going beyond simple acceptance of needing to be alcohol-free:

> "This is a new chapter in my life and it's very different. I am absolutely delighted with it...I'm really happy." (Hayley, ex-member, 3-years alcohol-free)

Yasmin (browser, 18-months alcohol-free) indicated this happiness came from arriving at her "authentic self". Participants explained part of this authenticity involved a change of lifestyle and engagement with new activities (e.g., study, exercise, volunteering). It also meant a "sense of freedom" because they reached a point of openness both online and offline:

> "I don't care what people know about me, you know at the meet ups we use our real name and photographs were taken...couldn't care less now if some of my personal friends think that I was an 'alcoholic'...that's the label they might want to use." (Karen, member, 13-months alcohol-free).

Some participants even described becoming "evangelical" about their sobriety by shouting about the benefits of not drinking and recruit people to the "sober revolution" (Ian, browser, 5-years alcohol-free). Others also expressed passion in discussing *Soberistas* – Linda said, "I'm a Soberista and proud of it!" (Member, 15-months alcohol-free).

3.5. Life going forward: moving beyond a 'Soberistas identity'

Participants described 'moving on' from *Soberistas* at different stages in their recovery journey. Many who reached a stage of security and authenticity moved on because they no longer relied on it to maintain sobriety, or felt the need to give back any more – *"It fulfilled its function...I am in control of my addiction and I feel perfectly able to deal with it"* (Ben, member, 3-years alcohol-free). Dave agreed:

> *"I feel like in my journey I have taken everything out of Soberistas as I can, and put as much back in as I could – but I'm in a different stage of my journey now and I don't really need it."* (Member, 1-year alcohol-free)

Others moved on because their peer group had dissolved, Paul explained:

> *"There were just a few small groups of people I seemed to connect with, and the sad thing is they disappeared – it's a bit wearing having to explain yourself to new contacts all the time, so this year I have shied away from the chat side of things."* (Member, currently drinking).

Similarly, Karen said the only reason she would leave *Soberistas* is *"not being able to relate to people"* (member, 13-months alcohol-free). Several longer-term alcohol-free participants described feeling like "outsiders" because of the increasing number of new members who were only recently abstinent:

> *"I'm one of the old timers...with two years under my belt, I'm now looking, well there are people who are seven days and eight days...that's not me anymore."* (Kevin, member, 2-years alcohol-free).

Longer-term alcohol-free members perceived their needs to be different from newly-abstinent members and often withdrew from *Soberistas* when it no longer resonated with them. However, because many considered the site to be an important part of their recovery journey, they often felt a deep "attachment" to it and continued to pay the subscription fee to support it financially and/or *"keep the security blanket"* (Kerry, member, 3-months alcohol-free). Just as Caroline said that *"sobriety and recovery is an ongoing journey, it never ends"* (member, 3-years alcohol-free), 'moving on' from *Soberistas* was rarely seen as finite.

4. Discussion

This paper explores the role of one online mutual aid group in helping people address their problematic alcohol use. Our analysis, grounded in participants' accounts, highlighted key stages of engagement with *Soberistas*, through which on- and off-line identities could be constructed and adjusted to support recovery. The most linear and commonly discussed pathway of engagement involved transitions from 'lurking' to 'participating' to 'leading', before 'moving on'; this journey coincided with participants' journey from problematic alcohol use to being "secure in sobriety".

Caution is needed in generalising our findings to other online groups for alcohol or different addictions. We did not intend to recruit a representative sample of people who access online support groups, but chose instead to explore the views and experiences of members and browsers of one group to develop theory as to how it may effect change. Given the scarcity of research in this area, and the increasing popularity of internet-based self-support, our findings may deepen understanding of how engagement with online mutual aid might facilitate recovery, highlighting its role in identity construction. By situating our findings within the broader recovery literature, our data may have relevance beyond our sample.

Our results demonstrate the internet's role in personal recovery journeys, and support the conceptualisation of identity as multidimensional and fluid, which we suggest might be key to understanding the mechanism of action of online mutual aid. Online networks allow control over how users present themselves (Merolli et al., 2013; Walther, 1996); individuals balance their need for connection and understanding with their desire for anonymity. 'Lurking' afforded participants the opportunity to gain information and reassurance from similar people who had quit drinking, but also maintain secrecy about their continued use of alcohol or ambivalence toward change. Upon joining *Soberistas*, many participants reported feeling ashamed or scared of revealing their drinking identity with people offline, including professionals, perhaps due to perceived stigma of problematic drinking – engagement with an online group was considered safe as it need not interfere with other offline identities (e.g., a parent at home, or an employee at work).

If the *Soberistas* identity (including values and norms around abstinence) resonated, participants often continued engagement by actively participating; internalisation of the group identity through this engagement may have supported recovery by facilitating the development of a stable non-drinking social identity (Best et al., 2015; Frings and Albery, 2015). While some participants revealed personal information to other online users through the formation of smaller communities or in-person meetings, others maintained anonymity. The option for restricting identity related to drinking to an online network was considered a benefit over in-person treatment, which lacks this flexibility. Furthermore, online accountability comes with it freedom to break away – participants could easily move on without consequence.

Some participants allowed their on- and off-line identities to be viewed simultaneously; this was most common for leaders and those firmly alcohol-free who had established an 'authentic identity'. For these participants, their online non-drinking identity (constructed through the internalisation of *Soberistas*' recovery-orientated norms and values), blurred into their offline identities, and changes in 'real-life' social networks and activities were described. The 'crystallised self' theory (Tracy and Trethewey, 2005) posits that multiple facets of self are healthy and functional, however a 'drinking identity' can interfere with many other identities (e.g., as a parent, an employee, or an "efficient coper"). Participants typically described this facet as destructive, and spoke of feeling liberated when both on- and off-line identities were defined by abstinence. Some participants were open and honest about their alcohol-free status on- and off-line, despite resistance from friends, family and/or colleagues, potentially having internalised the *Soberistas* group norms, which then become a personal resource in times of adversity (Jetten et al., 2014). The convergence of on- and off-line identities, although problematic in some situations (see McEwan and Mease, 2013), was considered a positive step forward in recovery for some participants.

It is important to return to a key study finding concerning the inability of the site to support moderated consumption (in keeping with AA philosophy). This alcohol-free ethos could isolate individuals who relapse after a period of abstinence, or are seeking a non-abstinence recovery path. Indeed, participants who resumed drinking often described leaving the site until they were ready to contemplate abstinence again. Other research has noted moderation as a viable recovery option, and this serves as an alternative approach to that offered by *Soberistas* or AA (see Klaw and Humphrey's (2000) and Humphrey and Klaw's (2001) work on 'Moderation Management').

4.1. Conclusion

The use of qualitative methods provides insight into how this sample used a non-12-step orientated online mutual aid group to

address problematic alcohol use. Our findings extend literature that highlights the role of identity in recovery, and how engagement with internet-based groups may help facilitate this. Online groups appear to provide an alternative for people who experience barriers in accessing traditional services, and may serve as a place to explore their relationship with alcohol at early stages of change. Clinicians in non-alcohol-specialist services might consider signposting to such groups that require little prior commitment on behalf of the client. Future research is needed to explore the role of gender in online mutual aid, as most of our participants were female. Identity processes in other online groups using different models of mutual aid, or for people with other addictions, also require further exploration of how engagement with online mutual aid may help initiate as well as support recovery.

Conflict of interest

Role of funding source

Contributors

Sophia E Chambers conducted participant interviews, led analysis, interpreted the results, and drafted the first manuscript. Julia MA Sinclair and Krysia Canvin contributed to the study design, qualitative analysis and interpretation. David S Baldwin contributed to interpretation of analysis and provided editorial direction for all drafts of the text. All authors have contributed substantively to and have approved the final manuscript.

Acknowledgments

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