MAKING SENSE OF ALCOHOL DEPENDENCE: EXPLORING THE BELIEFS OF ADULT CHILDREN OF PROBLEM ALCOHOL USERS

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ABSTRACT

The research literature concerning individuals who have experienced parental alcohol dependence during childhood has primarily focused on the harmful psychological and social consequences arising from such an experience. Relatively little research has focused on positive outcomes, or the various psychological factors that might mediate the relationship between the experience of growing up with an alcohol-dependent parent and outcomes in adulthood. In addition, very few studies have used qualitative methods to explore the significance and meanings that children of alcohol-dependent parents attach to their experiences.

The current study employed a qualitative methodology to explore the beliefs held by individuals affected by parental alcohol dependence regarding the nature of, and responsibility for, alcohol dependence. Data was collected and analysed using a Grounded Theory framework, based on interviews with ten individuals. The findings revealed that through an active sense-making process, participants had developed a wide range of interrelated beliefs regarding alcohol dependence and its development. They also held a number of attitudes towards the responsibility for alcohol dependence and experienced a variety of dilemmas and ambivalent emotions relating to these.

The findings are reviewed in relation to the wider literature regarding children of alcohol-dependent parents, attribution theory and the diagnostic criteria for alcohol dependence. Implications for clinical practice and service delivery are considered in terms of individual and family interventions, and training.

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CHAPTER 1:

INTRODUCTION

1.1 OVERVIEW OF CHAPTER

The introductory chapter comprises six sections and aims to provide a context to the present study. Following an overview, Section 1.2 introduces the concept of alcohol dependence, and outlines some of the popular discourses regarding the nature of alcohol use. Section 1.3 describes the relationship between alcohol dependence and the family, and is followed by a review in Section 1.4 of the literature that specifically focuses on the outcomes for, and experiences of, children of alcohol-dependent parents. Section 1.5 presents an examination of the literature concerning social cognition (i.e., the way that people make sense of their social world). This includes a discussion of attribution theory and related models that attempt to link beliefs with action. Finally, Section 1.6 presents a brief discussion regarding the clinical relevance of conducting research with people affected by parental alcohol dependence and a rationale for the aims of the current study.

In the preparation of this chapter, a literature search was performed on three databases regarding psychological, sociological, medical and nursing research: PubMed, PsycInfo and Web of Science. All three databases were searched up to the end of June 2009, using the search terms *alcohol dependence*, *alcoholism*, *children of alcoholics*, *parental alcohol use, attributions* and *Brickman model*. Bibliographies were also hand-searched for additional references.

1.2 ALCOHOL DEPENDENCE

1.2.1 Definitions and diagnostic criteria

The concept of alcohol dependence was first proposed in the mid-1970s by Edwards and Gross (1976) who outlined a provisional description of a clinical syndrome that comprised 'elements' such as tolerance, withdrawal and compulsive urges to drink alcohol (see Box 1).

Box 1. Essential elements of the 'alcohol dependence' syndrome (Edwards & Gross, 1976):

- Narrowing of the drinking repertoire
- Salience of drink-seeking behaviour
- Increased tolerance to alcohol
- Repeated withdrawal symptoms
- Relief or avoidance of withdrawal symptoms by further drinking
- Subjective awareness of compulsion to drink
- Reinstatement of drinking after abstinence

Tolerance may be defined as the 'need for markedly increased amounts of the substance to achieve intoxication or desired effect' and a 'markedly diminished effect with continued use of the same amount of the substance' (APA, 1994). Withdrawal may be manifested as a cluster of symptoms that appears following the sudden discontinuation of substance use, and includes an individual's attempts to alleviate the accompanying discomfort by taking the same, or a closely related, substance.

As these definitions suggest, characteristics such as tolerance and withdrawal are not unique to alcohol dependence but are believed to feature in conditions involving a range of

substances (Teesson *et al*., 2002). For example, the International Classification of Diseases (ICD-10; World Health Organisation, 2007; online version) describes a related concept, the 'dependence syndrome', as:

> 'A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. The dependence syndrome may be present for a specific psychoactive substance (e.g., tobacco, alcohol, or diazepam), for a class of substances (e.g., opioids), or for a wider range of pharmacologically different psychoactive substances.'

The ICD-10 classification system also describes a variety of other related categories of disorder such as 'acute intoxication', 'harmful use' and 'withdrawal state' which involve the problematic use of substances. Therefore, there is some debate as to whether alcohol use disorders should be conceptualised as categorical or dimensional conditions (e.g., Helzer *et al*., 2006), and also whether there may be clinically meaningful subtypes of alcohol dependence. For example, Hesselbrock and Hesselbrock (2006) have proposed that there may be as many as four homogeneous types of alcohol dependence: a 'chronic/severe' type, a 'depressed/anxious' type, a 'mildly affected' type and an 'antisocial' type.

In addition, the terms 'addiction' and 'addictive behaviours' are frequently used within the literature, and they allow for a greater range of behaviours (other than those involving consuming substances) to be classified as having the potential to lead to a state of dependence. Thus, alcohol dependence falls within a broad spectrum of problematic and impulse-control behaviours which may be conceptualised in a number of different ways. For the sake of clarity within this study alcohol dependence will be operationalised as alcohol-related 'behaviour over which an individual has impaired control with harmful consequences' (West, 2001). These consequences may have implications for both the individual and those around them and are briefly discussed below.

1.2.2. Consequences of alcohol dependence for the individual and wider society

Alcohol dependence and related conditions are now considered to be a major public health problem, with alcohol use being causally linked to more than 60 different medical disorders (Room *et al*., 2005). These include malignant neoplasms such as liver and breast cancer, cardiovascular disorders and gastrointestinal diseases. With regard to injury, there is a well-established link between excessive alcohol consumption and aggressive behaviour; for example, in 2006/7, just over a half of violent attackers were believed to be under the influence of alcohol by their victims at the time of the incident (NHS Information Centre, 2008). Alcohol dependence has also been found to be associated with a range of mental health problems such as depression, anxiety, bipolar disorder, psychosis and in particular, anti-social personality disorder (Institute of Alcohol Studies, 2007), although the causal relationships between these conditions have yet to be elucidated.

It has been estimated that alcohol misuse costs the National Health Service alone between £1.4 and £1.7 billion per year, £75 to £250 million of which is spent on specialised alcohol treatment services (Luty & Carnwath, 2008). Therefore, it is vital that effective interventions at both individual and community levels continue to be developed and implemented. Currently, the treatment of alcohol use disorders may be categorised into: brief interventions (predominantly delivered by primary care practitioners), specialised treatment programmes (mainly undertaken within secondary and tertiary care services), and mutual help groups (generally found within the voluntary sector; e.g., 12-Step groups such as Alcoholics Anonymous). In addition, government policy (e.g., the Alcohol Harm Reduction Strategy for England: Cabinet Office, 2004; Safe, Sensible and Social: Department of Health, 2007) aims to reduce the harm associated with alcohol consumption in various ways; for example, by controlling the blood alcohol limit for drunk driving, carrying out public awareness-raising initiatives, regulating alcohol taxation and working 'in partnership' with the alcohol industry (Hall, 2005).

1.2.3. Popular discourses regarding the nature of alcohol use and dependence

Alcoholic beverages, produced via the fermentation process, have been a feature of human societies since the beginning of recorded history (Room *et al*., 2005). Over time, social commentators have provided us with many insights into the various discourses around alcohol consumption, and have highlighted the ambivalence around its use and misuse across cultures. However, this discussion will predominantly focus on literature from the UK and will at times refer to substance dependence more generally where there are significant overlaps between beliefs about addictions to different substances.

Prior to the nineteenth century, a 'moral model' of alcohol use prevailed, whereby excessive consumption was regarded to be a consequence of 'free will' and therefore resulted from an 'intrinsic weakness in the individual' (Albery & Munafo, 2008). Proponents of this model advocated that punishment was necessary to control alcohol consumption, with total abstinence as the desired outcome. Substantial temperance movements developed in many countries where Protestant Christianity was powerful, until eventually a 'new compromise was reached [whereby] alcohol was no longer viewed as a threat to all, but rather to a small subclass of ... people who were alcohol dependent' (Room *et al*., 2005).

In the nineteenth century, addictive behaviours increasingly became conceptualised as biomedical problems (a re-conceptualisation that is often referred to as the 'disease model'), which placed an emphasis on the addictive properties of the substance as opposed to the characteristics of the individual (Albery & Munafo, 2008). Anderson (2007) describes the multiple and often conflicting views regarding alcohol use in Britain in the 1920s. The three dominant positions were that some argued for total abstinence, others defended drinking alcohol as an integral part of working-class life, and yet others urged the government to nationalise and therefore regulate the alcohol industry. Melley (2002; as cited by Bailey, 2005) highlights the continuing contradictory nature of beliefs about addiction; for example, it is still 'seen as being at once both utterly normal and dangerously pathological'.

Chick (1993) has noted that today there appears to be a movement away from the biomedical approach to alcohol problems and suggests that there are various benefits and drawbacks of such a departure. He concludes that although a uni-dimensional view of alcohol dependence is unhelpful and 'illness' should not be necessary for help to be offered, diagnosis of a syndrome may be initially useful for planning treatment. In the current scientific literature, theories regarding substance dependence may be grouped into five themes (West, 2001):

- Broad conceptualisations comprising biopsychosocial factors;
- Models that seek to explain the dependence liability of particular stimuli;
- Theories that focus on the dependence liability of particular individuals;
- Models that explore the environmental and social conditions that give rise to addictive behaviours;
- Theories that focus on relapse and recovery.

The breadth of these theories suggests that alcohol dependence is increasingly seen as a multi-faceted phenomenon which arises from complex interactions between an individual's genetic and psychological make-up and their social and physical context. However, West (2001) states that some of the most significant advances in the control of addiction have emerged without reference to sophisticated theories. There are likely to be a number of advantages and disadvantages to taking a more simplified position with regard to alcohol dependence. In terms of government strategy, Anderson (2007) argues that current alcohol policy is seriously flawed and ultimately 'disables public interest ... through its framing of

alcohol-related problems in individual terms without attention to their social context' (Anderson, 2007). He criticises the 2003 Licensing Act, which limits licensing power to the 'prevention of crime and disorder, public safety, the prevention of public nuisance and the prevention of children from harm, and not with the public health' (Anderson, 2007; p. 1516). This works to locate responsibility for minimising alcohol-related health problems on individuals themselves.

Consistent with this view, Bailey (2005) notes that many of the popular discourses of substance dependence see the addiction as 'inherent in the person', who is 'actively engaged in their own behaviour, and therefore with a capacity to stop'. From a sociological perspective, Du Gay (1996; as cited by Bailey, 2005) has argued that the development of the modern concept of addiction may be linked to a 'contemporary emphasis upon consumption as a form of identity' and may even represent the 'logical extreme of such a consumption identity'. These viewpoints appear to locate the responsibility for controlling drinking behaviour within the individual, yet give consideration to wider socio-cultural factors that may contribute to the development of substance dependence.

1.3 ALCOHOL DEPENDENCE AND THE FAMILY

> 'Alcohol presents two faces to the family. One face is that of a beneficial and healthful beverage that fosters warmth and intimacy. The other face is that of a potentially hazardous potion that jeopardises one's family through conflict, violence and deprivation' (Leonard & Eiden, 2007; p.286).

The above quote reflects the ambivalence discussed within the previous section regarding discourses whereby members of society appear to hold contradictory beliefs about alcohol use. The tensions between positive and negative aspects of alcohol use and their impacts on the family are complicated further by the bi-directional nature of the alcohol-family relationship. In a recent review of marital and family processes in the context of alcohol use, Leonard and Eiden (2007) describe how excessive drinking and alcohol disorders are often 'knotted together' with other family disturbances. The inter-relationships between these issues present researchers with complicated methodological challenges. However, the accumulated literature regarding alcohol-related problems and the family unit now allows researchers to draw some conclusions about the nature of family life when one or more members are dependent on alcohol.

In terms of the relationship between alcohol use and transitions in the family life cycle, Leonard and Rothbard (1999) found that excessive drinking could influence the timing of marriage, either advancing it or delaying it. Following marriage, a phenomenon termed the 'marriage effect' has been found to occur in younger adults, females in particular, whereby excessive drinking is reduced over the transition to married life. Bachman *et al*. (2002) have suggested that this effect may be mediated by a number of variables, such as changes in religiosity, social-recreational activities, friends' alcohol use and normative views of alcohol use.

Another phenomenon reported to occur is known as 'assortative mating', which refers to the tendency for alcohol-dependent people to be more likely to be married to other alcohol-

dependent people than would be expected by chance alone (e.g., Jacob & Bremer, 1986). However, Leonard and Eiden (2007) note that such studies do not take factors such as spousal influence and differential divorce rates into account. Spousal influence refers to the effect that partners have on one another's attitudes and behaviours. An example of this from the alcohol-family literature was reported by McAweeney and colleagues (2005) who found that one of the predictors of husband recovery from alcohol dependence was whether his spouse had an alcohol disorder at baseline.

Domestic violence has also been linked with alcohol consumption. Indeed, excessive alcohol consumption and alcohol problems are well-established correlates of men's violence towards women, although the relationship between women's drinking and intimate partner violence is less robust (Leonard & Eiden, 2007). The inclusion of relationship-focused components into more traditional treatments for alcohol dependence may help to simultaneously alleviate marital discord and decrease alcohol consumption. For example, combined 'alcoholism and behavioural couples therapy' (ABCT) has been found to reduce violent behaviour, particularly among alcohol-dependent males in remission (O'Farrell *et al*., 2004).

Significant negative correlations between alcohol consumption and marital satisfaction have been reported in the literature (Marshall, 2003) and it is likely that causality is bidirectional here. Floyd *et al*. (2006) found that positive interaction behaviours were highest among couples in which either both or neither individual had a diagnosis of alcohol dependence, and lowest among couples consisting of an alcohol-dependent husband and a non alcohol-

dependent wife. Efforts to investigate the hypothesis that marital satisfaction may also influence drinking behaviour have found some supportive evidence. In a longitudinal study involving approximately 1700 married men and women, Whisman and colleagues (2006) found that baseline marital dissatisfaction predicted occurrence of an alcohol disorder after controlling for lifetime alcohol disorders.

Other transitions in the family life cycle include separations and the addition of new family members, and these events have been associated with changes in drinking behaviour. Both cross-sectional and longitudinal studies (e.g., Bachman *et al*., 1997) show that divorced men and women are more likely to drink excessively than single men and women. They are also more likely to experience alcohol-related problems, although the results from one study indicated that problem-drinking women may be at a reduced risk for alcohol problems following a divorce (Wilsnack *et al*., 1991). Leonard and Eiden (2007) suggest that this may be due to distance from a heavy-drinking or stress-inducing partner.

During pregnancy there is a marked decrease in the mother's alcohol consumption, although there is generally a subsequent rapid increase during the postnatal period (Homish, 2004). In terms of parenting behaviour, Leonard and Eiden (2007) observe that there appears to be a 'circular loop' between parents' alcohol dependence, children's behaviour problems and parenting. They discuss how alcohol-dependent parents are at higher risk for having children with behaviour problems (discussed further in the next section), and that these problems may then increase parental stress and lead to further alcohol consumption. Leonard and Eiden (2007) also state that there is some evidence of

differential parenting behaviours between antisocial and non-antisocial alcohol-dependent individuals. They describe a potential 'interleaving between heavy drinking and antisociality that together could have a very disruptive effect on the marriage and that could be involved in the intergenerational transmission of these two problems' (Leonard & Eiden, 2007; p.302).

The research discussed in the current section has so far focused on the interactions between family relationships and alcohol use. However, there is also literature that explores other issues that the family might face together. For example, Velleman (1993) has described the impact that alcohol dependence might have on rituals and routines within the home. He argues that a substantial part of family life consists of repeated gathering and specific patterns of interacting. However, the often unpredictable behaviour of an alcohol-dependent family member means that forward-planning may be made more difficult and even if the relative in question appears to withdraw from the family, they may nonetheless come to dominate family events.

Velleman (1993) also lists roles, communication, social life and finances as other major areas of potential distress for families. With regard to roles, there may be changes to the division of labour within the household as the alcohol-dependent relative progressively becomes less able or willing to take on tasks. Partners and children may experience increased stress due to the added care-giving burden they are required to carry. In terms of communication, Velleman notes that it is not only the emotional quality of communication that may change (e.g., ominous silence or verbal abuse) but the content of discussions may frequently centre

on alcohol or alcohol-related problems. Changes to the family's social life may involve a growing sense of isolation due to difficulties with attending social gatherings, inviting people to the house or because of feeling unable to disclose the problem drinking to friends, neighbours and other family members. Finally, financial pressures may be a major strain for families, and the likely lack of disposable income due to increased spending on alcohol and the possibility of job loss may have a substantial impact on the quality of family life.

Therefore, it can be seen that alcohol may become a central focus in many families involving an alcohol-dependent member and ultimately the stability of the family may come to revolve around concerns associated with alcohol (Saatcioglu *et al*., 2006). Family members are likely to be faced with stressful dilemmas on a regular basis, regarding the best way to respond with such concerns. A typology of coping responses, derived from both quantitative and qualitative studies, has been developed by Orford (1992) and this includes eight major categories:

- *Emotional*: expressions of strong emotion towards the user on account of their use;
- *Tolerant*: actions that support or aid use, or which protect the user from harmful consequences of use;
- *Avoiding*: deliberately putting distance between self and the user on account of the latter's use;
- *Controlling*: attempts to directly control use or events directly related to it;
- *Confronting*: calm, open communication to the user about the relative's own position and needs;

- *Supporting the user*: actions that directly support the user in modifying use or in pursuing alternative personal goals;
- *Independent*: actions indicating personal independence or lack of dependence on the user;
- *Inactive*: responses indicating lack of action.

Orford (1992) notes that family members may also frequently experience a lack of support in their coping efforts due to factors such as family discord, encouragement of drinking behaviour by significant others and the lack of a cohesive plan for coping.

In summary, the literature demonstrates that alcohol-related problems may cause significant difficulties for the family as a unit. In addition, there are specific issues associated with growing up as the child of an alcohol-dependent parent and these are the focus of the next section.

1.4 CHILDREN OF ALCOHOL-DEPENDENT PARENTS

There is now a substantial literature regarding the impact of experiencing parental alcohol dependence during childhood. Early studies were mainly concerned with investigating the outcomes of such circumstances, with a particular focus on later alcohol consumption and behavioural difficulties (e.g., Sher, 1991). Later, researchers began to examine the mediating and moderating factors associated with these outcomes, and to identify possible trajectories from childhood through adolescence to adulthood (e.g., Velleman & Orford, 1999). In recent years, there has been a shift away from identifying the key risk factors and

more of an emphasis on resilience and understanding the viewpoint of children of alcohol-dependent parents 'in their own words' (e.g., Moe *et al*., 2007). This section presents an overview of the research in this area to date and a discussion of some of the methodological considerations that may influence interpretation of the data.

1.4.1. Psychosocial characteristics of children of alcohol-dependent parents (COAs)

Although the focus of the current section relates to the issue of parental alcohol dependence during childhood, it should be noted that many of the studies conducted in this area have been cross-sectional in nature, and have involved primarily young adults. In addition, there is an associated literature regarding foetal alcohol syndrome (or foetal alcohol effects) which may occur following maternal alcohol use during pregnancy (e.g., Carmichael Olson *et al*., 2001). However, it is beyond the scope of the present study to review this related research.

One of the most widely investigated outcomes in the field of COA research is that regarding alcohol use during adolescence and later adulthood (Sher, 1991). A review by Harter (2000) concluded that COAs are consistently found to be at risk for developing alcohol and other substance use problems compared with the general population. This risk has been found to be magnified in families in which the parents exhibit greater congruence in their drinking patterns and in their values regarding alcohol use (McCord, 1988). A recent study explored 'telescoping effects', whereby a rapid acceleration of alcohol-related problems occurs following drinking onset (Hussong *et al*., 2008). The results indicated that COAs progressed more quickly from initial adolescent alcohol use to the onset of disorder than do matched

controls. The authors note that a substantial proportion of COAs evidencing an alcohol use disorder by early adulthood will show a developmentally limited profile (i.e., many will desist as opposed to persist with their problematic drinking behaviour). Consistent with this, Ellis *et al*. (1997) have commented that the increased risk of developing alcohol dependence seen in COAs may not persist into late adulthood.

Findings such as these suggest that there may be subgroups of COAs who vary in the degree to which they are at risk for developing persistent problematic drinking styles. Velleman and Orford (1999) found that although COAs were more likely than comparison groups to be heavy, risky or problematic users of alcohol, the differences were not as great as expected and not always statistically significant. In addition, their results showed that COAs also more frequently reported that they were current abstainers or comparatively infrequent, light drinkers. Studies investigating drinking restraint (a cognitive preoccupation with control over drinking) have shown that adolescent COAs have been found to report higher levels of drinking restraint than non-COAs (Chassin & Barrera, 1993). The authors reported that this higher restraint was in turn associated with more drinking overall, a commonly found effect in studies within the general population (e.g., Collins & Lapp, 1992). However, Trim and Chassin (2004) found a quadratic effect (i.e., those at the highest and lowest levels of restraint were less likely to develop later alcohol dependence). Therefore, it is possible that drinking restraint has differential effects on drinking behaviour in COA subpopulations.

In comparison with non-COA participants, COAs have also been found to differ in the various alcohol-related cognitions they may hold; for example, alcohol expectancies and schemata.

Research by Zucker and colleagues (1995) showed that COAs from the age of three years were better able to identify at least one alcoholic beverage, were better able to identify specific alcoholic beverages and were able to identify a larger number of alcoholic beverages than non-COAs. Several studies have indicated that COAs reported more positive expectancies regarding the effects of alcohol, such as an increased positive emotional state, a decrease in tension, enhanced sociability and improved motor performance (Brown *et al*., 1987; Sher *et al*., 1991; Lundahl *et al*., 1997). Expectancies are 'expectations regarding the effects of alcohol that are predictive of individual differences in drinking behaviour ... [and may] serve as mediators that account for how a COA's internalised observations of parental drinking influence his or her decisions about drinking' (Ellis *et al*., 1997).

COA research has also focused on other areas of mental health functioning, which are often classified as internalising problems (including depression, anxiety and social withdrawal) and externalising problems (including physical aggression, oppositional or defiant behaviours, engagement in illegal activities). Overall, studies suggest an increase in depressive symptomatology, specific anxiety disorders, generalised distress and lowered self-esteem in COAs compared with non-COAs (Harter, 2000). However, the results are mixed with regard to internalising problems, and it is likely that the relationship between parental alcohol use and later psychological functioning is multi-faceted and complex. For example, Harter and Vanecek (2000) found that the family environment was more strongly associated with negative assumptions about the self and the benevolence of the world than parental alcoholism or childhood abuse.

The relationship between parental alcohol dependence and externalising problems is more consistent and the majority of study findings indicate increased antisocial or under-controlled behaviour in COAs (Lieberman, 2000). This relationship remains even after controlling for other parental pathology and childhood abuse (Harter, 2000). With regard to interpersonal relationships, there is some support for the notion that COAs experience greater difficulties experiencing secure attachment and establishing trust with others. For example, Kelley *et al*. (2005) reported that young adult COAs reported more anxious and avoidant behaviour in romantic relationships and a more fearful style of general adult attachment than non-COAs. Further research is needed to clarify the nature of the possible interpersonal problems faced by COAs and explore the potential associations between these and other aspects of psychosocial functioning.

1.4.2 Developmental trajectories, risk and resilience

Moving beyond the research that examines relatively simple comparisons between COA and non-COA groups, a wealth of studies focuses on exploring COA trajectories from youth to adulthood. Some models have emphasised the importance of considering gene x environment interactions, which consider both biological predisposition and environmental risk when predicting outcomes (e.g., McGue, 1997; Enoch, 2006). However, the majority of studies have investigated associations between various psychosocial risk or protective factors and outcomes such as alcohol consumption and internalising or externalising symptoms.

Ellis and colleagues (1997) have proposed that family influences on risk fall into two categories: 'alcohol-specific family influences', which selectively predict alcohol abuse and alcoholism; and 'alcohol-nonspecific family influences', which predict both alcoholism and other psychiatric problems. They suggest that alcohol-specific influences include factors such as parental modelling of drinking behaviour as a coping method, alcohol expectancies and drinking practices that vary according to cultural norms. Alcohol-nonspecific family influences include parental psychopathology, socioeconomic status, general family psychopathology, family aggression and violence and parental cognitive impairment. Consistent with this hypothesis, Chassin *et al*. (1991) found that parents' alcohol problems were uniquely predictive of adolescent alcohol involvement and internalising problems; parents' antisocial behaviour was uniquely predictive of drug use and externalising problems; and parents' affective disorder was uniquely predictive of internalising problems.

A number of longitudinal studies have provided insights into the possible pathways to the development of drug and alcohol dependence in COAs. In a review of the literature on biopsychosocial risk factors for alcohol use disorders, Zucker (2006) outlines a trajectory from an association between father's alcoholism and difficult temperament in infancy, to behavioural under-control and a greater frequency of externalising problems in early childhood. From there, the research data are predictive of the development of conduct disorder in middle childhood, and finally increased antisocial behaviour and substance abuse in adolescence and adulthood. Edwards and colleagues (2006) found that non-COAs show a typical developmental trajectory of increasing aggressive behaviour from 18 to 36 months, and then a rapid decline between three and four years. However, their results

showed that COAs did not exhibit this normative decline at three years of age, and the authors noted that cumulative family risk (comprising other parental psychopathology, family conflict and negative parenting) was predictive of higher aggression at baseline.

The concept of cumulative family risk is particularly relevant to COA research, which indicates that people growing up with one or more alcohol-dependent parents are likely to be subjected to a range of other adverse childhood experiences such as various forms of abuse, neglect and household dysfunction (Dube *et al*., 2001). The relative density of such risk factors has been linked with the heterogeneity often observed in COAs' family experiences. For example, Zucker *et al*. (1996; as cited by Harter, 2000) have found that, by sub-typing 'alcoholic families' based on the presence or absence of antisocial personality disorder, it is possible to identify highly troubled families in whom a variety of risk factors aggregate. However, there is some debate regarding 'uniformity myths' (Mintz *et al*, 1995) which imply homogeneity within subgroups. Harter (2000) states that there is little empirical support for 'adult COA syndromes', suggesting that 'comorbid parental pathology, childhood abuse, family dysfunction and other childhood stressors may contribute to or produce similar outcomes'.

Less research has been conducted into the protective factors and processes that might minimise the negative impact of parental alcohol misuse. Resilience in COAs is an area of study currently emerging and suggests that, with regard to certain areas of functioning, COAs may appear to be not only resilient (e.g., Moe *et al*., 2007) but thriving compared with comparison groups (Holstein, 2006). A review by Velleman and Templeton (2007) describes

the outcomes that may suggest resilience in young people who have experienced stressors in early life. These include deliberate planning by the child that their adult life will be different, high self-esteem and self-efficacy, an ability to deal with change and a range of problem-solving skills. They list a number of protective factors which have been associated with such outcomes: the presence of and close positive bond with a stable adult figure, little separation from the primary carer in the first year of life, a good support network beyond the immediate family, engagement in a range of activities and positive opportunities at times of life transition.

In summary, the literature on outcomes and trajectories indicates that COAs are at an increased risk for problematic substance use and various other psychosocial difficulties, in particular externalising disorders. However, this research has found that COAs are also a heterogeneous group and suggest that there may be 'no single profile of COAs' (Gilvarry, 2005). A number of methodological considerations are worth noting when drawing conclusions from the largely quantitative data presented above. In terms of the generalisability of study findings, most of the research conducted has involved people with alcohol-dependent fathers, at a single point in time. This does not allow an exploration of the impact that fluctuating alcohol problems (e.g., remission and relapse) may have on the family system. Little research has investigated whether maternal versus paternal drinking problems, or where one versus both parents are alcohol-dependent, have differential effects on COA outcomes; and also whether there are cultural variations in the COA experience (although see Orford *et al*., 2005). Finally, very few studies have used qualitative

methods to explore the significance and meanings that COAs might attach to their experiences; and this is the focus of the next section.

1.4.3 Qualitative accounts of growing up with an alcohol-dependent parent

Of the qualitative studies that have been conducted with COAs, only two appear to have specifically focused on the experience of parental alcohol dependence where the participants were still living at home. An early study by Cork (1969) involved informal, unstructured interviews with children aged 10 to 16 and highlighted the heterogeneity of the COA experience. The study also described the often stressful and adversarial family and home environments that young people were exposed to. Moe and colleagues (2007) interviewed children aged 7 to 13 who were attending a Children's Programme at the Betty Ford Clinic in the US. The interview topic areas included feelings, knowledge of addiction, thoughts about their parents' drinking, knowledge of treatment, and recovery and resilience. The analysis was based on the young people's responses to questions about resilience and resulted in three major themes:

- *Substance abuse behaviour*, whereby children related being abstinent to 'having a good life';
- *Perceptions of substance abuse behaviour*, which indicated the roles of guilt, treatment, recovery and negative role models in developing resilience. For example, several children expressed the opinion that they felt a need to relieve themselves of the blame for their parents' drinking and that 'just knowing the truth about their parents' addiction' had been helpful;

- *Internal resources*, whereby the young people discussed how being able to discuss their feelings, learning about addiction and having a sense of being able to make choices in life led to feelings of well-being.

With regard to adult samples, Velleman & Orford (1990) used both quantitative and qualitative methods to explore COAs' recollections of their parents' drinking and its immediate effects. The qualitative interviews elicited very varied accounts of childhood, although a large majority described parental drinking problems that spanned their childhood and adolescent years without interruption and without treatment. In terms of the effects that parental alcohol dependence had had on life at home, participants described parental moodiness, unreliability and a tendency for the parent to upset or fail to join in with family activities. The key feelings that participants recalled were associated with worry, uncertainty, a sense of family instability, the experience of being caught between the interests of two parents and the burden of having to adopt certain adult roles.

More recently, Orford *et al*. (2005) conducted a large cross-cultural study of family members (including COAs), again using both quantitative and qualitative methods. In their exploration of the core common experiences of family members, four facets of stress and strain emerged, that related to:

- The deteriorated nature of the relationship between family member and relative;
- Threats to family and home life;
- Intense worry about the relative;

- Signs of strain for family members.

The authors described how family members used multiple coping methods, as well as the problematic nature of the social support received from others. Some of the many barriers to accessing effective social support included family members not involving others, others not wishing to become involved, others being critical, and others' support being experienced as unhelpful by family members.

In a Finnish study, Itäpuisto (2005) used qualitative methods to analyse both interview data and written reports of childhood experiences by adult COAs. The findings from this study indicated that, across the sample, there were differences in the ways that individuals defined problematic drinking. For example, some viewed alcohol as being the problem whereas others viewed drunken behaviour as the problem. As has been proposed within the quantitative studies discussed previously, the participants described the influence that alcohol could have on their parents' ability to parent effectively. In addition, there were impacts on the perception of family structure; for example, the alcohol-dependent parent frequently came to be seen as an 'outsider'. Clients rarely used the term 'family' when talking about their childhood experiences, identifying individual family members instead. It was also often the case that participants had a sense that the house they lived in was not really 'home', and Itäpuisto describes this phenomenon as a form of 'mental homelessness'.

Of the many worries and concerns the participants experienced as children, many mentioned the fear of fathers returning home, and conversely of mothers leaving home.

The positive and negative aspects of social support (from both the community and statutory services) were described, as in the studies by Orford *et al*. (2005). Rejection by neighbours and acquaintances led to feelings of isolation, and those people who did visit the family home tended to be drinking partners of the alcohol-dependent parent, which often aggravated an already tense environment. Finally, participants talked of the numerous care-giving behaviours they engaged in on a daily basis (directed towards themselves, their parents and siblings). In order to manage this, they employed a range of 'micro-coping strategies' (i.e., seemingly small actions that they hoped would improve the quality of daily life) such as hiding and diluting alcoholic beverages in the house or restricting the money available for buying more.

Thus, the qualitative research conducted to date adds to and extends the findings from quantitative studies by furthering our understanding of the particular stressors that COAs may experience during childhood and the ways they responded to these. It is unclear from these studies, though, how participants make sense of their parents' drinking behaviour and how or whether this affects the way they feel about themselves and alcohol.

1.5 SOCIAL COGNITION

Social cognition refers to the way that people appraise and navigate their social environments and is one of the dominant areas of research within the field of social psychology (Martin *et al*., 2007). Heider (1958) argued that people regularly use 'naive' or 'common-sense' psychological theories when inferring meaning regarding events and

behaviours. One of the key theories concerned with how people develop and respond to their causal understandings is attribution theory.

1.5.1. Attribution theory

Attribution theory is a 'collection of diverse theoretical and empirical contributions sharing several common concerns' (Gross, 2001), which originated in work conducted in the mid-1940s by Heider and colleagues (e.g., Heider & Simmel, 1944). It is beyond the scope of this study to review all of the scientific traditions linked with attribution theory. However, of the well-established theories, those that are of greatest relevance to the current research question are Kelley's (1967; 1972) covariation and configuration models, and Weiner's (1986) attributional theory of motivation.

In his covariation theory of attribution, Kelley (1967) drew from earlier work by Jones and Davis (1965) regarding dispositional versus situational factors. Dispositional factors are an individual's personality characteristics, whereas situational factors are stimuli in the environment, both of which may lead to the occurrence of particular behaviours. Jones and Davis (1965) proposed that when individuals encounter a novel or aversive event, they are compelled to seek an understanding of its cause, and tend to frame this in terms of either dispositional or situational factors. In making causal attributions, Kelley (1967) proposed that individuals use the 'principle of covariation' that states that 'an effect is attributed to one of its possible causes with which, over time, it covaries'. Therefore, people are more likely to assume that events are causally related if they repeatedly occur together. In

addition, Kelley hypothesised that there are three types of causal information that help people form attributions:

- *Consensus*; which refers to the extent to which other people behave the same way;
- *Distinctiveness*; which refers to the extent to which an individual behaves similarly across different situations;
- *Consistency*; which refers to how stable an individual's behaviour is over time when faced with the same situation.

Empirical studies have found partial support for the use of these three types of information; with the weakest effects associated with consensus information (Gross, 2001). However, occasionally there are situations whereby individuals do not have access to information regarding any of these categories, and in these instances Kelley (1972) suggested that people draw upon their own configurations of 'causal schemata'. These are preconceptions regarding the multiple necessary and sufficient causes required for an event to occur and are based on prior experience of cause-effect relationships.

In a review of attribution theory research, Kelley (1980) stated that, in addition to causal information and pre-existing beliefs about behaviour, individuals also need to be sufficiently motivated to make attributions. It was stated that 'a person's interests ... determine whether he seeks causal understanding in an open-ended way or is preoccupied with a particular causal question' (p.473). Kelley (1980) outlined a number of possible influences on the types of causal attributions that individuals are motivated to make, and these include

power imbalances between 'observer' and 'actor', various self-serving biases (e.g., self-enhancement and self-protection), and the desire to believe in a 'just world'. Motivations like these may give rise to phenomena such as the 'fundamental attribution error' (Ross, 1977) and the 'actor-observer' effect (Jones & Nisbett, 1971). The fundamental attribution error refers to the tendency to over-value dispositional explanations for other people's behaviour, therefore under-valuing situational explanations. The actor-observer effect refers to an individual's tendency to over-value situational factors and under-value dispositional ones when attempting to explain their own behaviour. Together, these biases result in the tendency for 'actors' to attribute their own behaviour more to situational than dispositional factors to a greater degree than 'observers' do.

Weiner (1986) added to this work on motivational processes by examining the emotional responses that individuals experience after making particular attributions and the implications these have for subsequent behaviour. Weiner (1986) proposed three dimensions of causality:

- *Locus*; which refers to the location of a cause (e.g., internal or external to the 'actor');
- *Stability*; which refers to the duration of a cause (e.g., constant or temporary);
- *Controllability*; which refers to the degree to which a cause may be wilfully changed.

On an intrapersonal level, Weiner (2000) proposes that these causal dimensions may influence self-directed feelings of pride, shame and guilt within an individual. For example, if

a person attributes failure at a task to an internal and uncontrollable cause, they are likely to feel ashamed, embarrassed or humiliated. On an interpersonal level, however, the same dimensions may influence other-directed feelings of anger or pity. An example of this would be whereby making attributions for another's failure to internal and uncontrollable causes may lead to feelings of sympathy and concern. Weiner (1993) argues that these affective responses have important implications for the course of action a person chooses to take. In a study on reactions to stigmatised groups, Weiner and colleagues (1988) examined the relationships between perceived responsibility, affective responses and intentions to help. The findings indicated that those individuals who were rated as highly responsible for their predicament (including substance misusers) evoked little pity and comparatively high anger and elicited low help-giving intentions.

1.5.2. Brickman model of helping and coping

In a similar vein, Brickman and colleagues (1982) developed a framework for understanding people's beliefs about helping and coping which has also been applied to alcohol-related behaviours (e.g., Palm, 2004). Within this framework, a distinction is made between attribution of responsibility for the cause of a problem and attribution of responsibility for a solution. From this, four 'models' may be derived which are outlined below:

- *Moral model*: the individual is assumed to be responsible for both the cause and the solution to a particular problem;
- *Medical model*: the individual is not assumed to be responsible for either the cause or the solution to the problem;

- *Enlightenment model*: the individual is assumed to be responsible for the cause but not the solution to the problem;
- *Compensatory model*: the individual is assumed not to be responsible for the cause but to be responsible for finding a solution.

Brickman *et al*. (1982) hypothesised that each set of assumptions has 'characteristic consequences for the competence, status and well-being' of actors and observers; therefore, the 'wrong' choice of model is likely to undermine effective helping and coping. A number of studies have explored the Brickman model in relation to alcohol dependence across a variety of different contexts. West and Power (1995) found that clients attending an alcohol treatment unit held a range of beliefs regarding responsibility for their alcohol dependence, although these did not readily fit with a global dimension of location of responsibility. Instead, the results from a factor analysis indicated that the clients' beliefs about the causes of their alcohol problems could be classified into three factors: bad luck, personal responsibility and disease concepts. In terms of their beliefs about recovery, three factors also emerged: personal responsibility, the importance of treatment and the importance of motivation.

With regard to staff members working with clients undergoing treatment for alcohol-related problems, findings have been inconsistent. Kloss and Lisman (2003) found that clinicians' attributions were generally consistent with a 'medical model', whereas Palm (2004) concluded that treatment staff as a whole subscribed to beliefs from both the 'moral' and 'compensatory' models (i.e., the majority of the treatment staff saw the individual as

partially responsible for the emergence of his or her alcohol or drug problems and fully responsible for solving the problems). Palm (2004) argued that 'real society' is also likely to use a mix of models and reminds us that this is not necessarily a novel idea, quoting Linsky (1972) who stated that 'beliefs about alcoholism are not tightly integrated into a consistent ideology among the public'.

Finally, Bennett (1995) used the Brickman model to examine responsibility for alcoholism within the context of families in which there was an alcohol-dependent parent, and found that, in general, partners of alcohol-dependent individuals fitted the 'compensatory model' best. Bennett (1995) also highlighted how the different explanatory models that families hold may often trigger strong feelings of guilt, blame and shame for different family members.

1.5.3. Further research examining attributions regarding alcohol use and misuse

The literature concerning the attributions people make about alcohol consumption covers a variety of different alcohol-related behaviours from a number of perspectives. Studies have investigated attributions made by the general public, clinicians, alcohol-dependent clients and family members; and some of the affective and behavioural consequences of these.

With regard to alcohol-related violence, Paglia and Room (1998) found that the majority of adults participating in a survey study believed that an intoxicated person should be held responsible for their aggressive behaviour. Although alcohol was identified as a causal agent in situations involving violence, this did not decrease personal responsibility attributions.

The authors noted that 'consequence severity' has previously been found to be an important factor in attributions of responsibility and punishment, although they did not assess this directly in their study. Leigh and Aramburu (1994) report similar findings in their research involving vignettes describing a domestic violence scenario. The results indicated that the presence of alcohol increased the amount of blame directed towards *both* victim and aggressor, contrary to their hypothesis that it would lead to a discounting of responsibility.

In their attributional model of clinical judgement, López & Wolkenstein (1990) draw from Weiner's (1986) model and argue that attributions made about clients mediate the affective responses of clinicians towards them. These affective responses may then exert effects on the clinical decision-making process. They refer to previous studies (e.g., Batson, 1975) which have found that professional helpers are more likely to make dispositional attributions regarding a client's behaviour than laypeople, who are more inclined to focus on situational factors. López and Wolkenstein (1990) suggest that this difference may in part be explained by clinicians' training experiences, which often focus almost exclusively on intrapersonal issues; and their understanding that available resources are largely oriented towards changing people rather than systems.

Holleman and colleagues (2000) investigated the attributions made by primary care physicians and medical students in the US, and found that around half of the sample expected to 'fail' when caring for substance-dependent patients. The results showed that 'authoritarian' attitudes, depressed mood and poor tolerance of clinical uncertainty

contributed to more intensely negative attributions towards clients. Although these findings suggest that pessimistic beliefs may be fairly prevalent among clinicians, they do indicate that professionals' attributions do differ. It is unclear how attributions vary across clinicians although there is some evidence that the client's drug of choice may have an impact. For example, in a survey of general practitioners conducted in the UK, it was reported that the percentage of general practitioners willing to provide more services for alcohol misusers was over twice that willing to provide more for drug misusers (Mistral & Velleman, 2001).

In terms of service users themselves, the literature is relatively sparse. A study examining relapse experiences found that alcohol-dependent respondents made different attributions for their own relapses compared with the relapses of others (Seneviratne & Saunders, 2000). Participants explained their own relapses as caused by factors that they had little personal control over, whereas they associated others' relapses with high personal control. Kingree and Thompson (2000) found that in a sample of participants attending 12-Step groups, psychological well-being was negatively correlated with attribution of personal blame. They also found that of those who were also adult children of alcohol-dependent parents, there were higher levels of parental blame among females relative to males.

Niv and colleagues (2007) found that family members of relatives with both substance dependence and mental health diagnoses perceived them to have greater control over, and to be more responsible for, the causes of their psychiatric symptoms than did family members of clients diagnosed with 'severe mental illness' only. In addition, substance abuse on the part of their unwell relative elicited more negative affect from family members,

although the study did not examine helping behaviours. These findings again highlight the affective consequences of attributions, and the implications of these for mental health. As noted previously, powerful feelings of blame, shame and guilt are frequently experienced by family members who have an alcohol-dependent relative.

1.6. RATIONALE FOR THE STUDY AIMS AND CLINICAL RELEVANCE

The literature reviewed within this chapter indicates that a history of parental alcohol dependence may have profound immediate and lasting effects on individuals. It also suggests that within the general population there are a range of beliefs about the causes of, and responsibility for, alcohol use and misuse. These beliefs may have significant effects on the affective responses people have towards alcohol-dependent individuals and their inclinations to give help and support. The few studies that have examined family members' attributions regarding alcohol dependence indicate that relatives also hold a number of potentially conflicting beliefs which may be related to strong feelings of shame, blame and guilt. There appear to be no studies that explore COAs beliefs regarding the nature of and responsibility for alcohol dependence.

Therefore, this project has the following specific aims:

1. To explore the beliefs that people who have experienced parental alcohol dependence during childhood hold regarding the nature of, and responsibility for, alcohol dependence;

2. To explore the possible relationships between such beliefs and their own alcohol use;

3. To explore the possible relationships between such beliefs and feelings of guilt, shame and blame.

It has been estimated that between 780,000 and 1.3 million children in England live with a parent with an alcohol problem, and the number would be higher still if Scotland and Wales were included (Prime Minister's Strategy Unit, 2004; as cited by Forrester & Harwin, 2008). This indicates that there are potentially millions of adult COAs who have now left the family home. The findings from the present study may therefore inform clinical practice within both specialist substance misuse services and clinical psychology services (across the lifespan) more generally. The 'Models of Care for Alcohol Misusers' (DH/NTA; 2006) document produced by the Department of Health and the National Treatment Agency for Substance Misuse states that alcohol treatment services have a role to play in the provision of services to 'those affected by someone else's drinking'. In addition, the recent White Paper 'Every Child Matters' focuses on supporting all children, particularly those in vulnerable groups, to have better outcomes as adults. Given the multiple stressors faced by children exposed to parental alcohol dependence (e.g., Hall & Webster, 2007), and the risks regarding inter-generational transmission of addictive behaviours, it seems that both supportive and preventative work is needed within this population.

CHAPTER TWO:

METHODOLOGY

This chapter provides a description of the research methodology used, a rationale for its selection and a consideration of proposed guidelines for high quality and methodologically rigorous research (e.g., Elliott *et al*., 1999). In addition, the procedures involved in the research are presented and the participants are described.

2.1 DESIGN

A qualitative methodology, guided by the principles of Grounded Theory (Glaser & Strauss, 1967), was used to explore and develop an understanding of the beliefs held by people affected by parental alcohol dependence regarding the nature of alcohol dependence. Semi-structured interviews were conducted with ten individuals who had experienced parental alcohol dependence during childhood and were then analysed in order to generate a tentative theory.

2.2 GROUNDED THEORY

2.2.1 Philosophy and rationale

Grounded Theory is one of a number of different strands of research methodology that exists within the qualitative paradigm (Henwood & Pidgeon, 1995). Qualitative methodologies typically aim to understand the 'experiences and actions of people as they encounter, engage and live through situations' and to contribute to a 'process of revision

and enrichment of understanding, rather than to verify earlier conclusions or theory' (Elliott *et al*., 1999). Consistent with this, Grounded Theory is an inductive approach that was originally designed to facilitate the process of 'theory generation' as opposed to hypothesis-testing (Willig, 2001).

Grounded Theory was developed by sociologists, Glaser and Strauss (1967), who argued that the quantitative methodologies of the time did not allow new theories to emerge from data collected. They proposed a method for data analysis which ensured that the theories that arose would be 'grounded' in the data rather than being restricted by 'analytical constructs, categories or variables from pre-existing theories' (Willig, 2001). Grounded Theory has undergone a number of revisions since it was first put forward and the original authors themselves (Glaser & Strauss, 1967) later parted company and further conceptualised the model separately. The researcher has been guided by the style of Grounded Theory outlined by Corbin and Strauss (2008) as this acknowledges the role of existing theories in sensitising researchers during the research process.

In terms of limitations and criticisms of the Grounded Theory approach, these generally concern the method's epistemological origins. Willig (2001) comments that it has been argued that although Grounded Theory employs inductive techniques, it is still based upon an empiricist and positivist epistemology, i.e. it seeks to learn the 'truth' from the data. This appears to be inconsistent with many other qualitative approaches which stem from an epistemological position based on 'constructivism', i.e. that knowledge is produced or constructed by persons and within cultural, social and historical relationships (Henwood &

Pidgeon, 1995). This has led some researchers to develop social constructionist versions of Grounded Theory; for example, Charmaz, (1990; 1995), which propose that themes do not 'emerge' from the data but rather are actively constructed by the researcher. Pidgeon & Henwood (1997) recommend that researchers should carefully document each stage of the research process to increase reflexivity and aid transparency regarding how the theory has been constructed.

Grounded theory is compatible with a wide range of data collection techniques, although structured interview schedules are inappropriate (Bowers, 1988; as cited by Duffy *et al*., 2004). Semi-structured interviews allow flexibility in the sequencing of questions and in the depth of exploration (Fielding, 1994) - the use of more focused interview questions is consistent with the Grounded Theory approach but are generally used in later stages of data collection.

2.2.2 Process

In Grounded Theory, the processes of data collection and analysis are not seen as separate processes; rather the researcher moves between the two in an attempt to 'ground' the theory in the data as far as possible. The method incorporates both the progressive identification of categories of meaning from data and their integration, to create an explanatory framework. In this way, Grounded Theory refers to both a methodological process and an end product (Willig, 2001). Corbin & Strauss (2008) state that analysis involves taking data apart, conceptualising it and then 'developing those concepts in terms

of their properties and dimensions in order to determine what the parts tell us about the whole'.

2.2.2.1 Categories and coding

During the early stages of data analysis, sometimes termed 'open coding' (Strauss & Corbin, 1998), the coding process is largely descriptive. The researcher assigns labels to 'concepts' in the data and as the research process progresses, 'axial' coding increasingly involves the integration of low-level concepts into higher-level units of meaning or categories (Willig, 2001). Categories are groups of data that share central features or characteristics which may either be purely descriptive or more analytic in nature, whereby they interpret rather than simply label particular phenomena. Since Grounded Theory aims to develop 'new, context-specific' theories, categories should be labelled using 'in vivo' terms (i.e. those words or phrases used by participants themselves) as far as possible (Willig, 2001). In Grounded Theory, categories are not specified prior to data analysis (as in content analysis) but emerge and evolve throughout the research process from data collection onwards.

This movement from descriptive coding to analytic coding may be referred to as 'theoretical sensitivity' and here Grounded Theory acknowledges the role that the researcher's interaction with the data plays in this process. Theoretical sensitivity is derived through what the researcher 'brings to the study' as well as through 'immersion in the data' during data collection and analysis (Corbin & Strauss, 2008). 'Theoretical coding' involves the use of a coding paradigm which may sensitise the researcher to particular ways in which categories may be linked with one another (Willig, 2001). However, there is some debate in the

literature as to whether theoretical coding is appropriate or whether it unnecessarily constrains the analytic process (e.g. Glaser 1992).

2.2.2.2 Further strategies guiding data analysis

'Constant comparative analysis' refers to the identification of both similarities and differences within and between categories to enable further categories or sub-categories to emerge. In this way, the researcher simultaneously breaks down the data into smaller units while also merging units to form broader categories. This allows the 'full complexity and diversity of the data to be recognised ... (so that) all instances of variation are captured by the emerging theory' (Willig, 2001; p. 34). Similarly, the concept of 'negative case analysis' refers to the emphasis that researchers are required to place on attending to instances that do not fit within the emerging categories and overall theory.

'Theoretical sampling' refers to the collection of further data 'in the light of categories that have emerged from earlier stages of data analysis' (Willig, 2001). The basis for theoretical sampling is 'concepts not persons' (Corbin & Strauss, 2008), thus researchers are able to progressively refine the emerging theory by modifying the interview questions in order to either challenge or elaborate its developing assertions. This process of coding and sampling continues until the researcher is no longer able to identify any new categories, i.e. until 'theoretical saturation' is achieved. However, theoretical saturation may be seen as a 'goal rather than a reality' and Glaser and Strauss (1967; as cited by Dey, 1999; p.117) have commented on its elusive quality:

> ‘When generation of theory is the aim, however, one is constantly alert to emergent perspectives, what will change and help develop his theory. These perspectives can easily occur on the final day of study or when the manuscript is reviewed in page proof: so the published word is not the final one, but only a pause in the never-ending process of generating theory.’

Finally, ‘memo-writing’ is viewed as a key strategy for allowing researchers to gain analytic distance from the data. The researcher maintains a written record of the process of theory development; and memos generally include written definitions of categories, justifications of the labels chosen, comments on the nature in which categories may be connected and reflections on the original research questions and research process.

2.3 RELIABILITY AND VALIDITY

The increased use of qualitative methods in recent years has led to greater scrutiny of the nature of the knowledge produced by such research (Pope & Mays, 2006) and a proliferation of guidelines aimed at improving its quality. Based upon a literature review and peer consultation process, Elliott *et al*. (1999) present a set of guidelines for maximising the reliability and validity of qualitative research:

- *Owning one’s perspective*: authors should specify their theoretical orientations and attempt to recognise their values, interests and assumptions and the role that these play in their interpretation of the data;

- *Situating the sample*: authors should describe the participants and their life circumstances to aid the reader in judging the generalisability of the findings;
- *Grounding in examples*: authors should provide examples of the data to illustrate both the analytic procedures used in the study and the understanding developed in the light of them;
- *Providing credibility checks*: these should include measures such as checking the understanding of the data with the original informants or others similar to them, using multiple qualitative analysts, comparing two or more varied qualitative perspectives or where appropriate, 'triangulation' with external factors;
- *Coherence*: the understanding should be represented in a way that achieves coherence and integration while preserving nuances in the data (i.e. the understanding should fit together to form a data-based story/narrative, 'map', framework or underlying structure for the phenomenon or domain);
- *Accomplishing general versus specific research tasks*: general understandings of phenomena should be based on appropriate ranges of participants and situations and understandings of specific instances should be described systematically and comprehensively;
- *Resonating with readers*: the report should be presented in such a way that readers judge it to have represented accurately the subject matter or to have clarified or expanded their appreciation and understanding of it.

In their discussion of the issue of improving validity in qualitative research, Pope and Mays (2006) highlight guiding principles produced by Spencer and colleagues (2003), on behalf of

the UK Cabinet Office, for evaluating the quality of qualitative research. These indicate that qualitative research should be:

- *Contributory* in advancing wider knowledge or understanding about policy, practice or theory
- *Defensible* in design by providing a research strategy that can address the questions posed (i.e. the methods of enquiry should be appropriate to the objectives of the study)
- *Rigorous* in conduct through the systematic and transparent collection, analysis and interpretation of qualitative data
- *Credible* in claim through offering well-founded and plausible arguments about the significance of the evidence generated.

The methods outlined above were, as far as possible, incorporated into the research process, from design to report.

2.4 PROCEDURE

2.4.1 Development of the interview materials

The interview materials employed in this study were developed by the researcher on the basis of her clinical experience and in consultation with her clinical supervisor. As outlined in Chapter One, the study aimed to explore:

1. The beliefs that people who have experienced parental alcohol dependence during childhood hold regarding the nature of and responsibility for alcohol dependence;

2. The possible relationships between such beliefs and their own alcohol use;

3. The possible relationships between such beliefs and feelings of guilt, shame and blame.

A semi-structured interview schedule was constructed to reflect these areas of interest and incorporated a number of prompts to guide the research interviews (Appendix A). The schedule was designed to serve as a framework only and was therefore used flexibly so that participants were able to expand on issues and concerns that were pertinent for them.

2.4.2 Ethical considerations

Research proposals were submitted to the local Joint Trust/University Peer & Risk Review Committee and Research Ethics Committee in August 2008. The researcher attended a meeting of the Research Ethics Committee to discuss the application and, subject to minor revisions, a favourable opinion to carry out the study was granted by both committees by October 2008 (Appendix B).

In addition, the design of the project was discussed within a trustee meeting of the National Association for Children of Alcohol-dependent Parents (NACOA), a national charity based in Bristol which provides information, advice and support both for people affected by parental

alcohol use and for those concerned about their welfare. The trustees approved the study design, recruitment process and associated interview materials, requesting that the findings be published on the charity's website. A supporting letter from the organisation was included in the ethics application (Appendix C).

2.4.3 Recruitment

Letters of invitation were sent to potential participants by the Director of NACOA. The individuals contacted were those who had previously given consent to being contacted by NACOA about research conducted in association with the charity. The letters of invitation specified the area of research interest and provided a brief outline of the procedure (Appendix D).

A number of inclusion criteria were applied in the selection of participants:

- Males and females, aged 18 years or over;
- Individuals who experienced parental alcoholism (either one or both parents) within the family home, with the onset prior to 18 years of age.

Potential participants were asked to make contact with the researcher if they wished to receive further information about the study. The participant information sheet (Appendix E) included details of:

- The purpose, aims and objectives of the study;
- Information regarding inclusion and exclusion criteria for participation;
- The research process and procedures;

- Ethical aspects of the study (e.g. consent, confidentiality, the voluntary nature of participation, possible advantages and disadvantages of taking part);
- Details regarding the principal researcher and her role in undertaking the study.

Of the twelve individuals approached by the Director of NACOA, ten requested an information sheet and the researcher was able to arrange telephone screening appointments with all potential participants. The telephone screening appointment provided an opportunity to collect limited demographic information (regarding age, gender and ethnicity; Appendix F) and to address any questions or concerns that the person may have had at that stage. In addition, the researcher applied the following exclusion criteria in order to substantiate participants' COA status and minimise the possibility that participation in the research could act as a trigger for excessive drinking behaviour:

- A score of less than 3 on the Children of Alcoholics Screening Test (CAST-6; Jones, 1994). The CAST (Appendix G) is a frequently used instrument within the literature concerning individuals affected by parental alcohol dependence (Vail *et al*., 2000) and has been found to be a reliable and valid tool for use in research and clinical practice (Sheridan, 1995);
- A personal history of alcohol dependence, assessed using DSM-IV criteria as a guide.

2.4.4 Data collection and analysis

All ten individuals approached at the telephone screening stage were included in the study and mutually convenient interview dates were arranged. At the start of each meeting, the

researcher outlined the content and sequence of steps involved in the interview process. Prior to being asked to provide their written informed consent (Appendix H), the researcher gave the participant an opportunity to review the information sheet for the study. Whether or not the participants chose to do this, the researcher assured them that they could withdraw from the study at any time, without giving a reason, and that in the event of their withdrawal, any interview data that had been obtained would be destroyed.

Written informed consent was obtained for a number of different aspects of the study:

- Participation in the interview;
- Audio-taped recording of the interview;
- Possible publication of anonymised research findings.

Two copies of the consent form were signed by both the participant and the researcher, one for each individual to keep. Consent forms held by the researcher were stored separately from the rest of the participants' data.

Interviews took place at the offices of NACOA and their length ranged from 36 minutes to 58 minutes, lasting for 45 minutes on average. All interviews were audiotaped using a digital voice recorder and transcribed verbatim. The researcher also took notes during the interviews to capture key topics that were emphasised by participants.

Interviews began with general questions and prompts regarding the participants' beliefs about what might cause a person to become addicted to alcohol. Interviews then

progressed to discussions about how these beliefs may have developed and evolved over time, and whether they may be associated with particular feelings or behaviours. Following each interview, time was allowed for de-briefing, during which participants were invited to raise any issues regarding the personal impact of the interview. A reflective diary was kept throughout the data collection process (Appendix I).

With regard to analysis, transcribed interviews were first read (see Appendix J for interview excerpt) and summary memos written (Appendix K). The interviews and memos were then re-read several times and paragraph-by-paragraph 'open coding' was conducted. Following this initial coding stage, 'axial coding' was conducted, accompanied by notes to explain the decisions made by the researcher (Appendix L). Constant comparative analysis, negative case analysis and other strategies proposed by Corbin and Strauss (2008) were employed to aid the coding and integration process. N-VIVO research software was used to help manage, structure and make sense of the data set (see Appendix M for N-VIVO codes).

In terms of reliability and validity, the researcher used a variety of methods to ensure the high quality of the data; for example, the use of audio-taped and transcribed interviews, extensive cross-referencing of interview data, memos, theoretical notes and wide reading of COA research following completion of the interviews.

In addition, the researcher maintained an audit trail and sought feedback from their supervisors and study participants regarding the plausibility and credibility of the theory.

2.5 REFLEXIVITY AND PARTICIPANT DESCRIPTIONS

2.5.1 Researcher reflexivity

Reflexivity refers to sensitivity to the ways in which the researcher and the research process have shaped the data collected; and includes the role of prior assumptions and experience (Pope & Mays, 2006).

The researcher was an unmarried, white 28 year-old woman from a southern English middle-class background. She lived with her long-term male partner in south west England. She had experience of working in a variety of clinical settings in which the clients had presented with substance use problems. The researcher had also been involved with the NACOA organisation since the beginning of her undergraduate degree in 1999; initially as a volunteer helpline counsellor, then as a mentor and helpline supervisor and finally as a trustee.

Interest in the research topic was stimulated by the researcher's prior experience of conducting studies regarding the biological and psychological aspects of addiction (e.g. Field *et al*., 2004; Zetteler *et al*., 2005; Zetteler *et al*., 2006; Munafò *et al*., 2007). With regard to the current study, although the researcher used Grounded Theory techniques outlined by Corbin and Strauss (2008), her approach was also influenced by social constructionist ideas (e.g. Charmaz, 1990; 1995), in that she considered herself to be an active part of the theory generation process.

In terms of the researcher's own drinking behaviour, she is unable to recall her first alcoholic beverage but estimates that she would have first tried alcohol in her early teens. She enjoyed alcohol more for its drug effects than the taste, and has never been a heavy drinker. Following a diagnosis of glandular fever in 1997, the researcher was unable to drink any alcohol for a period of 12 months and this experience allowed her to consider some of the social and cultural aspects of drinking in UK society.

2.5.2 Group demographics

Ten individuals participated in study interviews, the majority of whom were female (n=8). The ages of participants ranged from 20 to 46 years (mean age: 30 years). Eight participants described themselves as 'white British', one used the term 'white', without specifying a nationality, and another used the term 'white European'. With regard to the CAST screening instrument used during the initial telephone contact, the group profile is shown in Table 1 below.

Table 1. Group scores on the Children of Alcoholics Screening Test

Item	**Number of 'yes' responses**
Have you ever thought that one of your parents had a drinking problem?	10
Did you ever encourage one of your parents to quit drinking?	4
Did you ever argue or fight with a parent when he or she was drinking?	9
Did you ever hear your parents fight when one of them was drunk?	9
Did you ever feel like hiding or emptying a parent's bottle of liquor?	6
Did you ever wish that a parent would stop drinking?	9

2.5.3 Participant profiles

Aside from the questions about alcohol dependence during the telephone screening process, participants were not asked any direct questions about their own level of alcohol consumption, childhood living circumstances or about the identity of their alcohol-dependent parent. The following information was obtained from the initial telephone contact and from examination of interview transcripts. Pseudonyms have been used for confidentiality purposes.

- 'Anna' was a 31 year old woman who described her ethnicity as 'white British'. Her father had been alcohol-dependent for as long as Anna could remember and continued to drink problematically at the time of the interview. During her childhood, she lived with her parents and older brother, and informed the researcher that her mother had died eight years ago. Anna also said that she had no concerns about her own drinking behaviour; she used to drink 'to get drunk' in her early teens, but would now describe herself as an 'occasional social drinker'.

- 'Beth' was a 20 year old woman who described her ethnicity as 'white'. She grew up with her parents and older brother and said that she became aware of her father being an 'alcoholic' when she was in her early teens. However, she said that she believed he had been alcohol-dependent for a long time prior to this, and he died of an alcohol-related condition a number of years ago. Beth reported that she enjoys drinking socially and apart from feeling worried about alcohol when she was younger, she now has 'no concerns at all' about her own drinking behaviour.

- ‘Charlie’ was a 23 year old man who described his ethnicity as ‘white British’. He grew up with his parents and younger sister. His father had been alcohol-dependent for as long as he could remember and Charlie reported that his father ‘could admit that he was an alcoholic’. In terms of his own drinking behaviour, Charlie said that he had tried alcohol at around the age of fifteen and mainly drank at weekends in his early teens. At university, he reported that alcohol had started to make him feel unwell and therefore he is now ‘almost teetotal’.

- ‘Denise’ was a 25 year old woman who described her ethnicity as ‘white British’. She described an extensive family history of alcohol dependence. In childhood, she lived with her parents, two brothers and a sister and said that her mother had been alcohol-dependent while she was growing up. Both her sister and one of her brothers now have ‘addiction problems’. In addition, her maternal grand-father and a number of aunts and cousins are ‘alcoholics’. She first became aware of her mother’s drinking being a problem when she was around nine years of age, and the label of ‘alcoholic’ was used when her mother started attending Alcoholics Anonymous. With regard to her own drinking behaviour, Denise previously went through a ‘phase of heavy drinking’ but drinks less alcohol now and does not feel concerned about her drinking behaviour.

- ‘Erica’ was a 41 year old woman who described her ethnicity as ‘white British’. She described growing up with both parents and a sister. She said that her father had a

'drinking problem' and that there was a strong 'drinking culture' within her immediate and extended family. Her sister also became alcohol-dependent and had died a year prior to the interview in an alcohol-related incident. Erica's earliest experiences with drinking alcohol occurred within her teens and she went through a phase of binge-drinking at one stage before her daughter was born. However, she did not believe that she had ever been dependent on alcohol and now considers herself to be an 'occasional drinker'.

- 'Frank' was a 46 year old man who described his ethnicity as 'white European'. During his childhood he lived with both of his parents and six siblings; one sister and five brothers (one of whom was adopted). He said that his mother was an 'alcoholic' and that his father had had a diagnosis of schizophrenia. He also disclosed that his ex-wife was a 'recovered alcoholic'. In terms of his own drinking behaviour, Frank described how he had started drinking in his early teens, and then had a period of complete abstinence between the ages of thirteen and nineteen years of age. After this time he had only drunk alcohol occasionally and said that he is now 'nearly teetotal'.

- 'Gaby' was a 36 year old woman who described her ethnicity as 'white British'. She grew up with her mother and two step-brothers from her mother's first marriage. Her father had lived with them for the first few years of her life until the family emigrated for a short period. Gaby said that both of her parents had had drinking problems, although her father's was less 'obvious' as he generally drank away from

the family home. She said that she had 'always known' her mother was a 'drinker' although only realised that she was a 'problem drinker' at around ten years of age. Her mother died eight months prior to the interview. Gaby herself 'doesn't really drink, except on very rare occasions'.

- 'Hannah' was a 31 year old woman who described her ethnicity as 'white British'. She described her mother as having a 'drink problem' for the whole of her early childhood, although recovered when Hannah was around 13-14 years of age and is now able to practise 'controlled drinking'. During her childhood, Hannah lived with both of her parents and her sister, and added that her grand-parents also provided a great deal of childcare support. Hannah said that she had 'never thought about' her mother's drinking while she was growing up; it was only when she became involved with NACOA that she 'really started thinking' about the issue. She said that although there have been occasions where she has felt concerned about her past heavy drinking behaviour, she does not believe that she has ever been alcohol-dependent.

- 'Isabel' was a 27 year old woman who described her ethnicity as 'white British'. She grew up with her mother, step-father and sister. Isabel described her step-father as being an 'alcoholic' and noted that his drinking behaviour had gradually escalated to becoming a problem when she was around 14-15 years old. Following a liver transplant operation, and without counselling or residential rehabilitation, her step-father recovered from his alcohol dependence. She also said that her maternal grand-father had been an 'alcoholic'. She said that she had never been concerned

about her own drinking behaviour but did have other alcohol-related concerns; for example, about 'worrying cultural norms' and a fear of possibly marrying an 'alcoholic'.

- 'Julia' was a 23 year old woman who described her ethnicity as 'white British'. Throughout both the telephone screening and face-to-face interview process she did not disclose any details regarding her family history or level of alcohol consumption, except to say that she had never been alcohol-dependent and was not concerned about her drinking behaviour.

The next chapter provides a description of the main findings from the study and includes a number of hypotheses that the researcher developed during the data analysis process.

CHAPTER THREE:

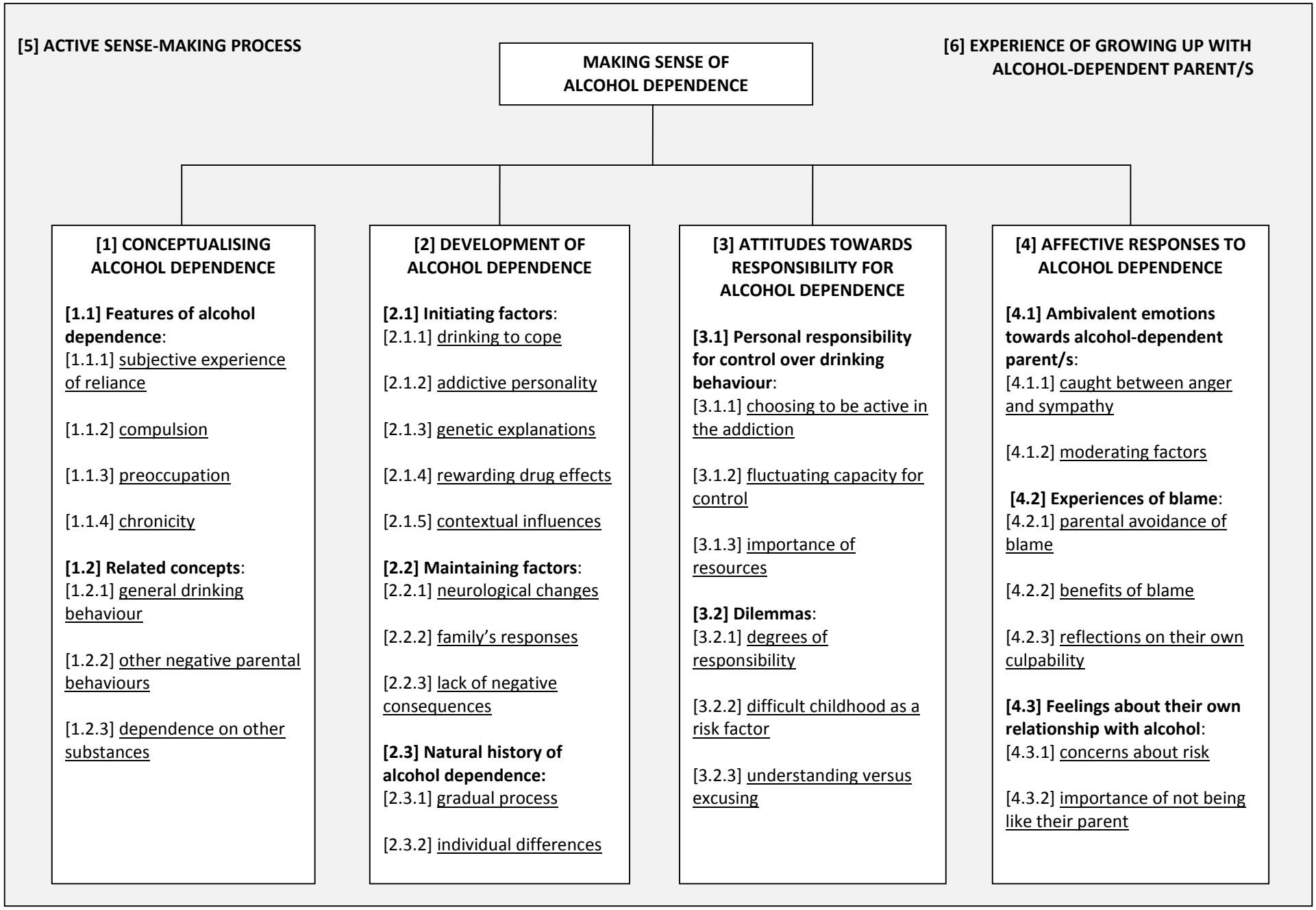
RESULTS

This chapter presents the key themes that emerged from the grounded theory analysis of data collected from the ten interviews. These themes are arranged into core categories, categories and sub-categories and are outlined in section 3.1. A diagrammatic model of the resulting grounded theory is presented in section 3.2 and this aims to clarify the propositions hypothesised to link the various categories together.

3.1 OUTLINE OF CORE CATEGORIES

The data are presented using the following convention: **CORE CATEGORIES** will be written in **BOLD UPPER CASE** font, **categories** will be written in **bold lowercase font**, and sub-categories will be written in underlined lowercase font. Core categories 1-4 are those that relate most directly to the research questions and are presented with a full breakdown of their contents. Core categories 5 and 6 comprise data volunteered by participants that did not directly relate to the research questions but provide useful background information regarding their experiences of growing up with alcohol-dependent parent/s and how their ideas about alcohol dependence developed over time. These latter two categories are included as uni-dimensional constructs, and are described briefly at the end of the section. Figure 1 shows a summary of all core categories and their corresponding categories and sub-categories. For clarity and ease of reading, the categories have been assigned numerical codes, in line with the nodes created using the N-VIVO software.

Figure 1. Summary of all core categories and their corresponding categories and sub-categories



3.1.1 CONCEPTUALISING ALCOHOL DEPENDENCE [1]

Definition: Participants' attempts to describe or define alcohol dependence as a concept. These comprised considerations regarding the various **features of alcohol dependence** and links with **related concepts** that either share these features or form part of the wider context for alcohol dependence.

Features of alcohol dependence [1.1]

This category refers to the various overt and covert attributes that participants associated with a state of alcohol dependence, i.e. how they would know that someone was dependent on alcohol. Many participants immediately widened their definitions to include substances other than alcohol, and even other behaviours.

Subjective experience of reliance [1.1.1]

Several participants described the subjective feelings that they imagined would accompany dependence on alcohol, drugs or other behaviours, for example:

Charlie: I suppose I would say alcohol dependence would be a state when you feel that you can't carry on, you can't live without alcohol.

Julia: I think it's when someone's really reliant on a behaviour or a substance and need it to feel normal or to function really. Then if they've not got it they feel out of kilter.

One participant suggested that this sense of reliance or need for a substance could be mediated by neural systems:

Frank: I think addiction is actually a chemical dependency; so with heroin, it's where your brain stops producing the natural opiates it produces to suppress pain. Then when you stop taking it your brain goes "where's all the opiates, where's all the pain relief?" So I think it's a chemical issue.

Compulsion [1.1.2]

Some participants also noted that in day-to-day life alcohol dependence may involve a powerful sense of being compelled to drink. Denise used examples from childhood experiences of observing her mother's drinking behaviour to illustrate how strong this compulsion could be:

Denise: I knew it was unavoidable and stuff. It wasn't a question of "could she?" it was a question of "she had to" and that was sad.

Isabel and Erica reflected on some of their own behaviours in order to relate to the dissonance that arises when compulsive behaviours conflict with other goals:

Isabel: It's where you're unable to stop using something despite the fact that you know that it's not something you want. For example, I smoke and when I don't want to smoke anymore I am unable to stop myself from having cigarettes. At the beginning of the day, I don't want a cigarette but by the end of the day I am like "well I'm going to have a better evening if I have a cigarette" and you come up with all these excuses and that to me is just the addiction inside you that's compelling you to do something even though your logical sense says "no", but you can't stop yourself.

Erica: I suffer from OCD and I've come to understand that as a form of addiction actually. When I am having an OCD experience, which normally for me now involves making sure the front door is shut, making sure I have turned off the gas and the electricity, it feels like an addiction when I am doing it. I know the door is shut and I know I have turned off the gas, but there is a compulsion that overrides everything and makes me go and check them again. I've been known to drive half-way to work and then drive home. It's like something else takes over.

Preoccupation [1.1.3]

Many of the participants talked about how important alcohol may become to alcohol-dependent individuals and that it could eventually eclipse all other activities:

Anna: You could see it in him that he was all the time thinking "what time is it? What time is it? Is there a chance? Is there an excuse?" You know, days like Christmas ... it would be, you know, drinking from first thing in the morning.

Charlie: I think eventually it just came to be such a feature of everything positive for my dad that he'd be drinking at home every weekend. He was a night-worker, so he'd have a couple of pints before he'd go to bed. And then he'd start missing work because he'd get up and not feel like going, then he'd drink that evening, and then eventually he was completely off work just due to drink.

Hannah commented that the apparent exclusivity of her mother's 'relationship' with alcohol resulted in her being unable to even think clearly any longer:

Hannah: She was drinking constantly, like every single morning, every day and I think that when you're drinking at that level you don't have moments of clarity because the only relationship you've really got is with the alcohol.

Chronicity [1.1.4]

Some participants also commented on whether they felt that alcohol dependence was a short-term or long-term condition, often using the subject of recovery as a way of framing their responses. There were a number of different views on this, such as the idea that alcohol dependence is a life-long concern:

Beth: They need to be aware that they're going to have to be active in not drinking for most of their life. If they do stop it's not just 'go to rehab once, then come out and everything's fine'.

Julia: And maybe they have to stop completely, like if it was alcohol or a drug, they couldn't just say cut down on it.

However, there was uncertainty about this issue, particularly for participants whose parents seemed to have made a full recovery and had been able to return to a non-dependent social drinking pattern, for example:

Hannah: That always makes me wonder because for some drinkers, if they ever drink again it's straight back into full-on alcoholism. So I don't know what makes my mum different because I know there are other people who were alcoholics like she was and that can be like her now but I know there's other people that just can't do that.

Related concepts [1.2]

All of the participants in the current study made links between alcohol dependence and a number of other associated concepts.

Dependence on other substances [1.2.3]

As stated earlier, when discussing dependence on alcohol, participants frequently also discussed addiction to other substances. Charlie reflected on the potential similarities between drugs in terms of the development of an addiction but noted that there may be differences with regard to initiation of use due to wider contextual factors:

Charlie: I suppose the process may be fairly similar for other drugs … I think it's just easier to get into that first stage, probably because of the availability and the lack of, sort of, social stigma about alcohol use.

This sentiment was echoed by Frank who could only find one difference between alcohol dependence and other substance dependence:

Frank: I think obviously there is a legal difference that alcohol is legal to certain people of a certain age. The purchase of alcohol is perfectly legal, whereas the purchase and say distribution of non-prescription drugs, those things like crack, the opiates and marijuana is actually illegal so it's got a different mechanism for getting out and about and getting to it.

Hannah commented on the role of psychoactive substances in society and did not make a distinction between the type of substance:

Hannah: You know, in every single society you come across, there is some kind of stimulant, some kind of drug that you find from a plant that we use to make ourselves feel different. Which I think comes back to that natural curiosity that human beings have got.

General drinking behaviour [1.2.1]

Several participants also considered the interface between dependent and non-dependent drinking behaviour:

Hannah: All people can be guilty of you know "I'm just going to have a glass of wine to relax". But then that can tie in with other things ... to become more of a need I think.

Gaby and Anna acknowledged that although many people regularly use and enjoy alcohol, there may be differences in the style of drinking and the functions that it serves for people who drink in a dependent way versus those who do not:

Gaby: When somebody dies and things like that, the first thing people do is have a stiff drink don't they? But then I think it's used more as a relaxant rather than something that's going to fix things.

Anna: I've a friend who's a very big drinker and he drinks and he loves his different reserve whiskeys and that kind of thing. And he really enjoys it. Whereas my dad will drink port from [supermarket name]. I suppose that's the difference in that my dad will literally drink anything.

Other negative parental behaviours [1.2.2]

In the context of having experienced often very difficult circumstances while growing up with alcohol-dependent parents, some participants viewed alcohol dependence as merely one of a number of negative or destructive behaviours that people may display:

Isabel: To me it almost wasn't the drinking that was causing the problems. The problem was just that he was an oppressive angry person. He doesn't drink anymore but he is still a horrible person ... although maybe he doesn't shout as much.

Anna: I suppose because his attitude and his drinking never changed, it's hard to blame the alcohol. I think if you took the alcohol away ... he would have still been a bit of a liability.

Julia suggested that alcohol dependence may be embedded within depressive symptomatology, although seemed uncertain as to the causal relationship between these concepts:

Julia: I think often in my mind depression is linked with alcoholism. But whether someone's already depressed and then they drink to cope or if it's the other way round, I don't really know. I think I'd see it as the depression coming first and then alcoholism or addiction being a symptom.

3.1.2 DEVELOPMENT OF ALCOHOL DEPENDENCE [2]

Definition: Participants' beliefs regarding the various factors that may cause an individual to become alcohol-dependent and stay alcohol-dependent; and how the natural history of an alcohol dependence problem may unfold over time.

Initiating factors [2.1]

Of the causal variables that participants described within the present study, there were some that appeared to refer more to predisposing and precipitating factors; i.e. those that were already present prior to the development of a state of alcohol dependence.

Drinking to cope [2.1.1]

All but one of the participants reported a belief that dependent use of alcohol may be a way of coping with stressful life events or feelings, for example:

Erica: I think my dad's addiction was about coping with some awful feelings.

Some of the participants used the term 'self-medication' to describe the situation whereby alcohol may be used to modify an individual's mood state:

Frank: In some cases it could be because of people feeling distressed, what people call "self-medication", in that they don't feel very happy with their life so they take a swig of beer or some sort of substance and that makes them feel better. And then the next one makes them feel a bit better.

Gaby: I have known people, they start having the odd drink on an evening, maybe a stiff drink to, you know, to numb the pain a bit because they're hurting or whatever. It helps them go to sleep so they don't have to think about it, sort of self medicating with it and then they can fall into it gradually where they can't not think about the pain unless they've had a drink.

Addictive personality [2.1.2]

All participants had views on whether and/or how an individual's personality might play a role in the development of a dependent drinking style, for example Beth:

Beth: From my experience I don't think that there are many people that have addictions that don't have an addictive personality type.

Beth went on to explain how an 'addictive personality type' might arise and how an individual with this personality type might present:

Beth: I think there's probably a genetic predisposition to an addictive personality type ... if you've got that then you're susceptible to be addicted to anything, not necessarily drugs or alcohol but it could be that you get quite obsessive about things. If you've got an addictive personality I think you think of yourself as a bit of a lone crusader. When you've got that kind of mentality, say if a bad experience happened to you, you wouldn't think to talk it through with somebody or to actively try to make the situation better ... you'd do something that just helps you and just worked for you which might be the alcohol which is where the problem starts.

Gaby also had ideas about how an addictive personality might manifest itself and the contextual factors that could influence its development:

Gaby: I think an addictive personality can sometimes be noticed from when those people were children. Maybe always having to be the centre of attention or, one minute they're mad on something and they have to do it to the fullest. And some parents sort of enable their children: "okay, you want to be a ballerina this week, let's go and buy the tutu", and let them be extreme about it. So I think sometimes not knowingly some parents help the feeding of it, if the addictive personality's already there. I don't know. Just sort of speculating.

Charlie said that he recognised elements of an 'addictive personality' within both himself and his father but hinted that this particular personality style may not inevitably lead to the development of addictive behaviours:

Charlie: I know from my experience that I've got a certain extent of an addictive personality but it's better directed than my father's was.

This sentiment was echoed by Frank who was unsure as to the sequence of the factors he considered relevant for the development of alcohol dependence:

Frank: I'm not quite sure about addictive personalities ... what comes first, the addiction or the personality, or the self-medication? I think people can have addictive personalities but then not go along a destructive path.

Denise and Anna were also uncertain about the validity of the 'addictive personality' construct, particularly in terms of where the boundaries between this kind of personality style and other personality traits might lie:

Denise: When I think about my brother or my sister or my mum, suddenly I can't really tell the difference between what is their addictive personality and what is just their personality. You know, we're probably all quite odd characters, even if we look at my youngest brother that doesn't have any kind of addiction problem, he's still quite reclusive and stuff. And I'm quite an anxious, worrying personality. So if I had an addiction, how much of that addiction would have been because I worry too much?

Anna: People talk a lot about addictive personalities but I don't think that you could say, you know, you have or you haven't got an addictive personality.

Genetic explanations [2.1.3]

A number of participants also commented on the role that an individual's genetic make-up may have on predisposing them to alcohol dependence:

Beth: It's run in his side of the family for years so there's obviously some sort of genetic thing.

Julia: I don't have a set thing in my mind of what it is, but definitely some element of an in-built or genetic thing or chemical imbalance.

Denise noted that a family history of alcohol dependence may partially involve a genetic component but also suggested that family dynamics could contribute to intergenerational transmission of dependent alcohol use:

Denise: I do think it's mostly down to genetics … although, I'm not too sure about how much is genetics and how much is family systems. So, like in my own family there's a long history of addiction and obviously I've got addiction in my close family. And that seems to have been passed down to my brother and my sister as well. But equally there's me and my other brother who are fine and not addicted. So, I'm intrigued because I wonder whether it's got something to do with our genetic makeup that got passed down, or whether there was something to do with our upbringing that was different. I'm the eldest and my other brother who's not addicted is the youngest. Did we experience anything in a different way from being the oldest and the youngest? I don't know.

Erica questioned the idea of an association between genes and dependence liabilities and also expressed a concern about the implications of relying on genetic explanations to justify dependent alcohol use:

Erica: I do sometimes wonder whether there is a genetic thing, whether some of us are more liable to become addicted. I think there are a proportion of people who are going to be but I've heard that nicotine is supposed to be really really addictive. Well I can take it or leave it. I think if people say it's genetic it's a cop out, because then it says "I have no control".

Rewarding drug effects [2.1.4]

A few participants reflected on how different people may respond to substances more or less positively, with the idea that alcohol-dependent individuals might find alcohol more intrinsically rewarding than other people:

Denise: The minute my sister and brother started drinking it really worked for them, and there was something different about it. I remember my brother, from a really young age, I don't know why my mum let him do it … but she let him drink like little bottles of beer ... they were tiny, so I suppose it didn't really matter but he used to really glug them back. And there was just something instant in it and the same for my sister. As soon as she started going out and partying after her GCSEs, that was it. She hasn't stopped the party. That's her phrase 'she went out to a party and she's just not come back'.

Isabel: I think another reason might be that to some people it's just a lot better when they have a drink; it's just amazing, whereas other people have a drink and think "yeah, that's quite nice but it's not that special to me".

Julia: Perhaps it's not so much because the alcohol helped them cope better but maybe the particular substance happened to be more addictive or they enjoyed the feelings of it more.

Contextual influences [2.1.5]

Julia and Erica mentioned the influence of family factors in the development of alcohol dependence:

Julia: It's also about how an individual has grown up in their family and learnt things, just passing on behaviours really, just by experience and observing them.

Erica: With my sister's addiction, it was the culture of the family. I think we grew up in a family where alcohol was the norm. And it probably took more strength to resist it, than it did to go along with it. I feel my mum might have an alcohol problem but it's because she has been married to my dad for so many years; she is like collateral damage I suppose.

Hannah widened this consideration of contextual influences to include societal norms and how they might increase the probability of developing a problematic drinking style:

Hannah: I think alcohol is so difficult because this is probably a cultural problem that we've got in Britain, that it's so socially acceptable to be a heavy drinker. You know even in my group of friends, it's that kind of thing where we go "have another drink, have another drink, have another drink". You know we don't always help each other with this whole situation.

Maintaining factors [2.2]

In addition to initiating factors, participants also spoke about causal variables that may play a role in perpetuating alcohol dependence.

Neurological changes [2.2.1]

Three participants tentatively commented on the role of neurological changes that might make it more difficult for a person to exert control over their drinking behaviour:

Anna: I've heard a lot about the physical things and the chemicals produced in the brain over time that, kind of, make it harder to stop drinking. You know, obviously that's nothing to do with people's character or anything. That's, you know, medical facts.

Frank: And that's when I think a chemical dependency develops ... where your brain gets used to that chemical, and almost a chemical starts substituting your own chemicals in your brain.

Hannah expressed some uncertainty as to how genetic factors and neurological changes might interact to produce a state of dependence on alcohol, and the temporal sequence of these interactions:

Hannah: I suppose nobody really, not concretely, knows what comes first, is it the genetic factor that makes you predisposed or is it that once you start drinking it affects your brain chemistry? Well we know it affects your brain chemistry, so therefore are those changes what then progress (sic) into the person becoming an addict? I don't know, it's interesting isn't it really?

Family's responses [2.2.2]

As with the initiating factors, participants also saw a possible role for family dynamics and individual family members' responses in maintaining problematic drinking behaviour:

Anna: My dad did actually stop drinking once for three days ... and just prowled the house like a mad man ... you know, 24 hours a day until my mum finally said, 'Fine ... do it'.

Beth: I probably didn't help the situation when I was a teenager but then he made me act in that way anyway ... it was his behaviour that I was reacting to.

One participant reflected that it was only as an adult that she was able to see the 'big picture' of the interpersonal system around her mother and how this impacted on her drinking behaviour:

Hannah: For your mum and dad to turn their back on you and for your husband to not to talk to you about anything, how awful and alone must you have felt, totally totally isolated. And it's only when you're an adult that you can kind of look at the whole big picture of that and actually see it from her point of view.

Lack of negative consequences [2.2.3]

A related aspect concerns the consequences that alcohol dependence may have for the individual and their significant others. Several participants noted that, within their own families of origin, the lack of overt negative consequences on family members had almost allowed the drinking parent to continue with their behaviour:

Anna: I think my mum was so good at keeping everything going that the drinking never became a major issue. So it was always keeping things just that little bit shitty but not so much that they fell apart I suppose.

Hannah: One thing I do think from my mum's situation was that she didn't have anybody that made her think "God if I do this I'm really letting this person down".

Gaby talked about how a similar process may occur outside of the family home, in the contacts that alcohol-dependent individuals have with friends and other people:

Gaby: You can get a bottle of alcohol in any corner shop with your shopping, it's totally socially acceptable. So alcoholics don't feel they're doing anything illegal, there's no boundaries to say that, "okay this is right and this is wrong". And they just look on it as though everybody must be like this, because usually people who drink are friends with other drinkers. Usually.

Natural history of alcohol dependence [2.3]

As well as having views on the kinds of causal factors that might impact on the development of alcohol dependence, participants also expressed beliefs about how a dependent drinking style might evolve.

Gradual process [2.3.1]

The majority of participants considered the development of alcohol dependence to be a slow, gradual process that may or may not involve an awareness of what is happening:

Frank: I don't think anyone sets out to be an alcoholic ... what happens is that it's a slow process that takes over. I think that during the early stages you can't sometimes recognise and perhaps say "this is not for me. No, tonight, I don't want to have that extra bottle of sherry; I don't want to get a bottle of wine".

Gaby: Nobody just becomes an alcoholic do they? It's usually a very slow process.

Denise: I don't ever imagine myself just suddenly, one day, falling into alcoholism and not being able to go the day without alcohol. I imagine I'd just avoid it before I got there.

Individual differences [2.3.2]

Most participants also expressed a belief that the way in which alcohol dependence might develop would vary across individuals, i.e. the specific causal factors and the relationships between them may be different:

Charlie: I suppose it's probably different for most people. I imagine some people begin drinking a lot more in response to negative things in their life, as an escape perhaps. Or for some I imagine they stay functional for a far longer period of time or some can stay functional, in some ways, almost perpetually. And I mean I would still count them as addicted if it was still part of their life that they couldn't live without … but they'd still be able to carry on. You wouldn't see them, sort of, laid up in a liver ward or something of that description.

Erica commented on how difficult it can be to predict who might develop an alcohol dependence problem:

Erica: I think it's a matter of luck. I think even if we have the same parents, every child is parented differently, so you can't have 'that happened, therefore that happened'. Because everybody's circumstances are different, your peer groups are different, you know little things that you can't possibly predict happen that might push you off into another direction.

Finally, Julia described a change in the way that she viewed individual differences, in that she was beginning to develop a more integrated view on how alcohol dependence might arise:

Julia: I did think quite differently for different people initially and now, looking back, I can see it in a more unified way. Perhaps at the time, particularly when younger, you see it differently for individuals.

3.1.3 ATTITUDES TOWARDS RESPONSIBILITY FOR ALCOHOL DEPENDENCE [3]

Definition: Evaluative beliefs held by participants regarding who is responsible for alcohol dependence, the factors that influence an individual's capacity for control over their own or someone else's drinking behaviour and the dilemmas that these issues raised for participants.

Personal responsibility [3.1]

The data indicated that most participants located responsibility for drinking within the alcohol-dependent individual, although this notion was qualified by a number of assumptions, discussed below.

Choosing to be active in the addiction [3.1.1]

Participants reported that regardless of whether or not the alcohol-dependent individual had been fully responsible for generating their drinking problem, they felt that there was still a degree of personal choice when it came to continuing to drink:

Julia: I think the point is that they still choose whether or not to actively take that drink. If it's an illness then they're going to have the craving for it, or need for it, and then need to get help to find other ways of dealing with it. So there is definitely still an element of choice in whether or not to be active in the addiction.

Beth: Ultimately it's the person that decides whether to pick up that glass or not. I think the people around you do shape who you are and your personality but at the same time you're conscious, you're aware of what you're doing and nobody's making you drink. Going back to the example of my dad, he knew he had an addictive personality type so he would never gamble because he knew that if he gambled he'd become addicted and he'd gamble everything away ... yet he chose to drink.

Gaby: It's down to the drinker. It has to be because they're the only ones that are drinking and whether it be no fault of their own, the reason why it started, they have to take responsibility of "this is my life, this is what I'm doing".

Although most participants endorsed this stance, there were some who expressed uncertainty about viewing drinking behaviour as a simple choice:

Charlie: So it's easy to say, "this person is more likely to drink because of X, Y and Z" but you know, "it's still you that has to deal with this." That's what it comes down to in the end, they're the ones with the most control over the situation. I mean, I think in a lot of situations maybe people do actually want to do it more than they might let on. It's like, sort of, you know, subconsciously. But still I don't think that necessarily it's just choice.

Isabel: I don't know, it's very difficult because I do think in some respects people don't have a choice over what happens to them. I think really the person drinking is responsible and that's not to say that you would blame somebody and say "look, that's terrible that you're drinking" but ultimately it can't be anybody else's responsibility but your own. I think although maybe there's no blame, there still has to be responsibility on the person.

Fluctuating capacity for control over drinking [3.1.2]

Participants also considered whether an individual's capacity for control over drinking may fluctuate over time:

Denise: She is still drinking, it's not like she's stopped being an addict, and stopped being in that place, but at the moment she's more in control, and so there are different points in people's life. I guess that's why it gets so difficult to judge really.

Erica: I think we all have choices. I just think some of us are more able, for whatever reason, to make the best of those choices and to make better choices. So I think to an extent we have personal choice, I think we can make choices, but sometimes our ability to make choices is limited by the environment in which we find ourselves.

Gaby described a developmental perspective with regard to this issue of varying levels of responsibility for, and control over, drinking behaviour:

Gaby: I think it probably goes back and forth throughout your life. Obviously when you're little then it's not your fault because your life is in somebody else's hands and then obviously when you're going through your 'finding yourself' years, then it could be still somebody else's fault but you need to start thinking because obviously that person's not going to fix it for you, or make it right or explain how or why.

Several participants used the term 'willpower' when reflecting on the ways in which control over drinking might change and the factors that might contribute to this process:

Hannah: Although I think it's a lot of your own responsibility, it takes a huge amount of will and when you're at your lowest ebb you haven't always got that. Whether it's something like depression or whether it is taking drugs or alcohol, whatever it might be, your willpower's completely gone sometimes isn't it?

Isabel: I do think that a certain amount is to do with willpower because I feel it myself in that sometimes I have got more willpower than at other times. Willpower is not as simple as "you've got it or you don't". It varies from person to person and within that person.

Importance of resources [3.1.3]

Participants spoke about the various resources that might be required for someone to be able to take responsibility for and exert control over their drinking behaviour, for example:

Isabel: I think people have got different resources, so for example, someone who's depressed doesn't have the same resources to exert willpower over an addiction than somebody who's very happy and in a very stable relationship. So I think it is who you are as a person, and also what's happening in your life at the time.

Some of the resources described were seen to be internal to the alcohol-dependent individual, for example self-awareness:

Julia: I think the individual always makes that choice whether to have another drink. But if they're doing it as a way of coping and surviving maybe they're not necessarily aware that it's something that's causing them harm or that they're addicted to it for quite a while maybe.

Beth: I think you need to be quite self-aware to say 'well I'd better not, like I'd better be careful about drinking or taking drugs or whatever'. My brother chooses not to drink because he knows that he's got quite an addictive personality but I think he's very aware that he controls it, he's the one that's responsible for that and that's how I feel as well.

External resources, such as social support from family and friends, were also mentioned:

Gaby: I think it also depends as well on the structure of the family; if there are lots of family members, if there are lots of siblings, if it's an only child and one parent. Because some people don't see their parents for years or don't have any contact with their family or there wasn't any family. So that can be quite difficult I think if somebody becomes addicted and there isn't anybody who cares to help.

However, several participants argued that without a desire to change, an alcohol-dependent individual would be unlikely to modify their drinking behaviour, no matter how many resources were available to them, for example Beth:

Beth: I don't think it matters who you've got around you, you could have the best people in the world and unless you want to do it, it's never going to happen. You can't just put somebody into rehab and expect it to work because they need to want to do it so I think although all the services are there, unless they're going to actively use them it's not going to do any good.

Dilemmas [3.2]

The discussions about responsibility for alcohol dependence raised a variety of philosophical and moral dilemmas for participants concerning how much responsibility individuals have over their behaviour and whether negative childhood experiences are always a risk factor and/or a justification for later problematic behaviours.

Degrees of responsibility [3.2.1]

A number of participants appeared to hold the belief that individuals are only partially responsible for their own drinking behaviour, but found it difficult to conceptualise how this responsibility might be shared:

Charlie: I, sort of, don't fall into either it's predetermined or it's completely a choice. I always want to say "it's responsibility, you've got a choice, you pick up that bottle or you don't." But at the same time, I'm aware that there are other factors. You know we're complex machines and we're not necessarily just simply free will.

Hannah: From my own point of view I think I'm the only one that can stop myself from doing something or not doing it, although at one point I was drinking quite heavily and my boyfriend who I'm no longer with never once said to me "you know that you're getting out of control". He never said it. I suppose to a degree I needed him to say "sort yourself out". So I don't know if it's a bit of a combination.

Isabel broached this issue by reflecting on her position in relation to the 'disease model' of addiction, which assumes that alcohol-dependent individuals have a lifelong illness that they have little or no control over:

Isabel: I'm not sure really. I think to me the disease model takes too much responsibility away from addiction, and that doesn't sit with me well because I think that it's not one way or the other. There will be some responsibility but not all responsibility. But I suppose I would probably sit closer to the disease model than having complete responsibility because I do think that life is quite cruel and people have to go through a lot of difficult things.

Isabel went on to use a metaphor involving 'teaching' to explain her views about degrees of partial responsibility:

Isabel: I think the majority of that has to be the person, I really do. I think it's the same with teaching, ultimately your responsibility is to give a certain amount of what is available. If you're sitting on one end of the table and they're sat at the other end of the table, they need to make steps, in that it's their responsibility to come to you and to work with what's being offered and that's probably not always easy.

Difficult childhood as a risk factor [3.2.2]

Participants held strong views on whether having had a 'bad childhood' could predispose an individual to develop alcohol dependence in later life:

Beth: I think it's easy to blame having a bad childhood or growing up around this or that to then be like "oh it's because of this that I drink and I've become an alcoholic because of that". I don't see it like that; I see it that you choose how you deal with your experiences, you choose how to move on from them ... because I don't think you ever leave things like that behind.

Julia: There are lots of people who do cope fine with life events and don't develop an addiction.

Some participants suggested that the experience of growing up with alcohol-dependent parent/s may not affect everyone in the same way, and appeared to have different moral perspectives on this:

Isabel: And you might have two children who come from similar backgrounds and bad things happened in their childhood and one doesn't drink and one does drink. Having things happen to you in your childhood, you can use that as an excuse for drinking, but at the same time you still have to accept that your path is your path.

Denise: I think we've all had problems; we all had a very difficult childhood. And two of us became addicts … but two of us didn't, so if it had just been my choice or it had just been something that I needed to do to self medicate … I could have dealt with my problems that way. But actually, that wasn't the solution to my problem and "it didn't work" in inverted commas.

Anna: I suppose I'm quite secure in the knowledge that I would never have a problem with drink. Although I can appreciate that people who grow up with parents who are alcoholic would fall towards it because it's just what ... what they learn.

Understanding versus excusing [3.2.3]

The process of exploring the possible causal factors that may contribute to an individual developing a dependence on alcohol appeared to raise anxieties for some participants, in terms of the extent to which these factors could somehow justify (as well as explain) behaviour:

Beth: Since he died I've found out more about him when he was younger and things from his childhood, and I kind of think "well, yeah, that's not very nice to happen" but then I think "well it's not as bad as what you did to us and we're fine". There's like certain things that went on his childhood and stuff which I could see would, if you're that way inclined, make you turn to drink but it doesn't make me think that it's okay ... in any way.

Charlie: I have a dilemma within myself, not just relating to alcohol, but relating to anything. For example, if being poor is being linked to being a criminal, does that excuse poor criminals? It's almost as if we were to talk about what contributes to it from almost a scientific detached sense … but at the same time not wanting to take the responsibility out of the hands of the individual.

Erica described the anger associated with experiences of her parents using causal factors as 'excuses' for abusive behaviour:

Erica: I can see why my dad ended up the way he did. I'm angry with him, and I am angry with my mum because they used his childhood as an excuse for him abusing me. But that's what I'm angry about, not the alcohol. I'm angry that "dad had a bad childhood; therefore he can abuse you, that explains his behaviour". That I think is where I am judgmental because I think people do have choices over how they act.

Similarly, Hannah talked about how the issues of understanding and excusing can become confused, resulting in a sense of 'letting them off the hook':

Hannah: It was only when I really had trouble I came to NACOA and I wonder if maybe somewhere in my subconscious I'd always wanted to know more or wanted to understand more but I'd never wanted to say that out loud because in a way maybe it was like letting them off the hook. And maybe, actually, even when we got past that point maybe I still wasn't ready to sort of say "yeah I totally forgive you".

3.1.4 AFFECTIVE RESPONSES TO ALCOHOL DEPENDENCE [4]

Definition: Participants' emotional reactions towards alcohol use; specifically their feelings about parental alcohol dependence, experiences of blame and their own drinking behaviour.

Ambivalent emotions towards alcohol-dependent parent/s [4.1]

Participants described a range of affective responses towards their parents' alcohol dependence, and also how these feelings could at times be moderated by various factors, such as level of self-awareness and neglect of parenting duties.

<u>Caught between anger and sympathy</u> [4.1.1]

Denise spoke of the often mixed emotions aroused by her mother's alcohol dependence:

Denise: Anger, grief, upset. And I suppose it's the rush of feelings that causes me to flip into a very, kind of, rigid "this is what parents should do" way of thinking. But eventually I can bring myself down from it. Even when she has been drinking, I think the best times have been when she's been open about it, although that's heart-breaking at the same time, because that really arouses feelings of sympathy.

Beth and Hannah also described a sense of ambivalence regarding whether to feel angry or sympathetic towards their parents' situations. Their accounts highlight the strength of the emotional conflict that they experienced and, for Hannah, the implications of this for her mental health:

Beth: I think it's when I hit my teenage years and it finally clicked, I was just like "oh I hate you" and you just think "why are you choosing to do this?" Especially when you're going through it, it's really hard to see that to a certain extent, it's not all them. It's weird really because at some level I feel sorry for them because I'm like "you've let your life get this bad, you've let something consume you so much that you can't see your way out". And at the same time I'm like "well, you chose to do it", you know, "deal with it".

Hannah: I think it is testament to her that she's come out of it now but at the time I was very bitter towards her. She overheard me and my sister talking about her once and when we realised we were so upset because as much as you hate someone you still love them. After that I then had a nervous breakdown because I'd never acknowledged anything about it and all I'd ever felt was anger towards her and then all of a sudden I couldn't hate her because I realised that she was suffering so much as well. Oh it was just awful.

Some participants described emotional conflicts of different kinds. For example, Frank reported anger followed by guilt about feeling this way towards his mother and how he subsequently managed this conflict by achieving a state of indifference:

Frank: The way it manifested in me was phenomenal anger towards her. A really big anger, and then also a very strong feeling of guilt for being angry with my mother. And I would go up there and just feel so angry all the time. I'm still angry at my mother, but I don't give a damn anymore. I no longer feel guilty about the anger. Basically I am indifferent to my mother now. So letting go of the guilt has also the effect that I am more indifferent towards her.

Moderating factors [4.1.2]

As well as describing their ambivalent emotional responses, participants also noted a number of factors that could moderate these feelings. For example, Julia explained that a lack of awareness on the part of the alcohol-dependent individual and increased understanding on the part of others could attenuate angry reactions:

Julia: I think it felt like some people were more aware of what they were doing whereas other people just had no idea, and then I might be less angry. Also, if you've got an element of understanding how they might have got to that point and why it might be very hard for them to get out of it then it's much easier not to be too angry at an individual.

Denise and Gaby talked about how feelings of anger and sympathy may be affected by the alcohol-dependent person's ability to fulfil their role as a parent:

Denise: Sometimes when I've been let down by my mum I feel that she's 100% responsible because she's supposed to be my mum. And she shouldn't have let me down that way, even though her behaviour was probably caused by her addiction. But at the same time the more rational part of me says, "well, that behaviour is caused by an addiction," and so she can't be 100% responsible for it. But I suppose it doesn't ever stop you feeling in that moment that the person is selfish. And that's just like one of those things that you've got to, kind of, contend with. I do judge her quite harshly. If she hasn't done something that I believe a parent should do for either me or my brothers or my sister, that's when I do find it very difficult to just accept that alcoholism might mean that she's not able to fulfil that role.

Gaby: I think alcoholics are very selfish. Or can be. But if they're drinking because of a grief, because of a relationship breakdown and it starts that way then I can sort of sympathise a little bit, as long as they're still doing what they need to be doing if they have children. I think the saddest thing is when it gets to that stage where they don't see anything wrong with using alcohol just to stop the shakes or the sweats or to get through the day ... I think alcoholics are very devious and I think they're just so desperate to be loved and needed and wanted, that's probably why they start drinking in the first place.

Frank commented on the discrepancy between the degree of anger he felt towards his father's mental health problems compared with his mother's alcohol dependence:

Frank: I was less angry with my father and his schizophrenia because that's a mental health problem, but when I was growing up I didn't see my mother as having a problem, she was a drunk, I didn't put the mental health aspect to it.

Experiences of blame [4.2]

The concept of blame was referred to in a number of different ways within the data set, with participants reflecting on the manner in which blame may be passed between people and how they made decisions regarding the amount of blame to take upon themselves.

Parental avoidance of blame [4.2.1]

Several participants recalled how their parents seemed to be invested in deflecting blame away from themselves:

Anna: He had lots of self-pity ... you could have lost an arm and he'd come in and say, "oh, you've got it easy. My life is terrible. I have to put up with you lot". And so it was very much that there was no blame to be given to him.

Frank: She used to blame my father for her drinking. My father had schizophrenia so the worst thing to give someone with schizophrenia who's taking medication is alcohol. But she would always blame him for the fact that she had to drink. All the time it was "I will have to get a drink because it will keep your dad calm, it will stop him getting angry". There was never any explanation that was more fundamental than that, but even as a naive kid, I knew my dad didn't really want to drink, he never started getting angry if there wasn't any drink in the house.

Isabel noted that she had heard about similar instances via working at NACOA, and the impact that this could have on a child:

Isabel: You hear about parents through the NACOA helpline who blame the children for things that are happening. And it's when the child is taking on the shame of what's happening with the parent because the parent is not talking about it and not allowing the child to see that it's something that's happened to them and it's nobody's fault.

Benefits of blame [4.2.2]

Two participants shared ideas they had about a blame avoidance process that may operate in wider society, for example with regard to media treatment of alcohol and other substance dependence and what might drive this:

Erica: It's only because people are too frightened to confront their own possibilities of addiction. It's easier to blame the other person than it is to look inside yourself and say; "I'm capable of this". I do know that we're all capable of doing these things, but most people don't want to admit it because it's too frightening; it's easier to blame the other person, to make it the other.

Hannah: It's like all of the stuff you see in the media about everything bad that ever happens, it's about saying "well we would never have done that, we would never have acted that way". Making something other than yourself because the only way you can actually deal with it is to think "if that person was evil and immoral and horrible, then that's why they've done what they've done and that's why they act in that way". It's easier than saying that person was a really great person who had a really awful experience and that led them to do this, because that means you actually have to deal with all the other stuff rather than just the actual drinking and drug taking.

Reflections on their own culpability [4.2.2]

In terms of the degree to which participants felt they could be blamed for their parents' alcohol dependence, some described a sense of uncertainty, for example Charlie:

Charlie: And, of course, if there are other factors that contribute, family is one of those factors. It's, you know, "how much culpability do I have here?" I mean, for example, in our situation it's difficult to know, were we good to my dad, bad to my dad, indifferent, slightly good, slightly bad. Would it have made any difference? Could we have been the best possible family ever? This stuff doesn't tend to come with a textbook, does it?

However, the majority of participants reported feeling that they were not to blame:

Erica: I don't think I would have felt ashamed. I felt frightened, I felt worthless and useless. But I don't think I ever felt ashamed. I didn't think I had anything to be ashamed of, although everyone in the family said I was a problem. I was a scapegoat.

Beth: I never really felt it was my fault particularly. I felt ashamed of him ... but I never felt that it was my fault.

Isabel shared this view but added that her stance towards blame may have been a way of coping with her family circumstances:

Isabel: I think I just turned my back on it and didn't see it as anything to do with me. I didn't feel as if it was my fault what was happening to the family, but I think a lot of what was going on was blocked out.

Feelings about their own relationship with alcohol [4.3]

Participants also talked about the affective responses they had towards their own drinking behaviour, in particular expressing concerns about the likelihood of themselves becoming alcohol-dependent, and therefore potentially being similar to their parent/s.

<u>Concerns about risk</u> [4.3.1]

Julia and Beth described the heightened awareness they had regarding their drinking patterns and how much control they might have over these:

Julia: I worry about my own patterns of behaviour or maybe if there is some kind of genetic susceptibility; patterns of behaviour within a family that might lead someone to be more likely to become addicted to something. I'm definitely aware of that.

Beth: I'm aware of my drinking patterns and kind of not letting there be a drinking pattern as such, just to drink when I want to drink ... not because other people are or something.

Participants seemed to have varying levels of certainty regarding their own level of risk. For example, Denise appeared to have a number of questions and doubts, whereas Hannah seemed to be more sure about her 'propensity towards drinking' and how she wanted to manage this:

Denise: I think there's always that part of me that's a little bit wary, that just thinks "it could happen". The other part of me thinks, "well, I'm old enough now and I've been down the pub enough to know that actually I think something would have happened by now." But there's definitely that part of me that does wonder "could it ever happen" … like, if something that I couldn't cope with happened, would there be a chance that suddenly that would be the thing that I needed? Would something change in my relationship with alcohol, I don't really know.

Hannah: I think the ultimate responsibility does lie with yourself because one thing that I recognise in myself is that I probably have a propensity towards drinking and I have to fight it.

Importance of not being like their parent [4.3.2]

Beth and Anna both emphasised how important it was that they did not replicate their alcohol-dependent parent's drinking style:

Beth: I so don't want to end up like my dad that I actively look at bits of myself and if I do go out and get drunk I find myself thinking "oh dear" ... whereas everyone else just went "oh that was a really good night", went to bed and woke up in the morning and were fine whereas I'd be like, "yeah that brings back memories" more than anything else.

Anna: When I was younger, as a student, I'd go out and drink and then get up in the morning, and the smell of myself and the smell of the room would make me think "that smells like my dad". And that's not a thing I want with me on a weekly basis or a monthly basis or anything like that, it's just not for me. I suppose I would be like him and that is the last thing that I'd ever want.

Frank commented on his feelings regarding his success at not becoming alcohol-dependent like his mother and that this was based on a conscious choice:

Frank: I suppose I am also a bit arrogant because I was raised in a household where mental health problems and alcohol abuse were very prevalent and yet I don't drink. So I made a choice at one stage in my life that I wouldn't drink. It would have been very easy for me to start drinking and become like my mother, an alcoholic.

3.1.5 ACTIVE SENSE-MAKING PROCESS [5]

This core category refers to the ways in which participants developed their understandings regarding alcohol dependence. As mentioned previously, core categories 5 and 6 will only be outlined briefly as they fall beyond the scope of the current research questions.

Participants had different experiences in terms of when they had recognised that their parent was alcohol dependent:

Anna: It was very much, you know, the 'emperor's new clothes'. Everybody just completely didn't speak about it. Regardless of my dad, the level of denial amongst me and my brother and my mum was pretty absolute as well. It wasn't until I was about 19 or 20 even ... that my mum finally said, you know, "I think he's an alcoholic".

Erica: I think the seeds for what I am thinking were always there. I could see my dad was an alcoholic from a young age.

However, once they had realised that their parent's drinking behaviour was problematic, the majority of participants in the current study then embarked on an active sense-making process in order to understand why this was the case:

Gaby: I always knew she drank because she used to go to pubs and she'd always be going out and whatever. I do remember seeing her drinking in the house; I wasn't aware if it was socially or not because you don't really sort of pay a lot of attention when you're that little. But I remember that I started to find glasses, like there'd be one in the laundry room, there'd be one in the bathroom cabinet, one next to her bed. I thought at first she was going mad and she was just forgetting. It became my mission then to get to the bottom of it.

Frank: Just observing. I come from a large family of five boys and one girl, and one adopted brother; so there were seven kids altogether and I suppose you learn more from your siblings about what's happening. We talked about it a lot after the event. Since we've all left home, we piece things together about how she used to drink and how she used to go across the

neighbours for a cup of coffee and stagger back because of the fact that she was drinking in the neighbour's house. But no one ever talked to me about it at the time.

Some participants also commented on their levels of motivation to understand their parent's drinking behaviour (and that of other people) and how this related to the feelings they had towards them, for example Hannah:

Hannah: Certainly when I was younger I didn't want to understand it. I just wanted to hold onto the angry feelings but as I've got older I suppose I do want to understand how she got to that point because I know she's unbelievably caring and loving and all these fantastic qualities. I've heard people talk at NACOA and I'm absolutely fascinated by their stories because I suppose it's that thirst to understand "why is he on that step?" Maybe it is that wanting to understand why they did it and how does that relate to your experience.

Denise noted that there was still a degree of uncertainty in her understanding of alcohol dependence/addiction and this appears to be a feature of many of the participants' quotes across categories:

Denise: Obviously being involved in NACOA I've learned more about addiction which is great. But, equally, I don't think any of the things that I've learned have been 'the answer' or 'the thing that solves addiction'.

3.1.6 EXPERIENCE OF GROWING UP WITH ALCOHOL-DEPENDENT PARENT/S [6]

In discussing their beliefs and feelings about the nature of alcohol dependence, participants frequently used examples from their childhood and these often included descriptions of what it was like growing up with an alcohol-dependent parent:

Isabel: I remember feeling as though I was living in a house that was oppressed. If he was in the house it was like a big black cloud and I didn't really want to go home and be a good girl and avoid the confrontations. But I wasn't growing up thinking about the drinking and worrying about him dying, which is strange because this time last year he was dying and he had to have a liver transplant.

Gaby: Even from a very young age she was always someone I felt I had to keep my eye on. It was really odd. She hasn't got any maternal skills. I had two brothers that she had from her first marriage that she ran away from to be with my dad. She sort of trapped my dad by

saying that her son wasn't her son, it was her nephew, you know, full of lies and deceit and whatever. And I just felt like "I've got to keep my eye on you".

Anna: It was as though he was always poised on the edge of his own personal tragedies ... but he always had this, you know, roof over his head and a wife and children and so to other people it probably looked like, you know, he was made.

Participants also spoke about some of the negative consequences of parental alcohol dependence, which included broken promises, aggression, restrictions on socialising and neglect of basic needs:

Frank: My mother used to say things like "I'm not drinking tonight" and I would be very elated that she wouldn't be drinking, but then at about 5.30 she'd go "oh I'll just get a bottle of cider" and she'd be on the cider, and then before long she would go out to get another bottle, and before long she was drunk. So in that perspective when I was a kid, I felt very betrayed ... she fooled me every time; when she said it I believed that she wouldn't be having a drink.

Erica: My memories of my dad quite often are that he was always down the pub; I always knew where to find him, he would go down the pub then bring back a two litre bottle of cider and drink and fall asleep and come up to bed about one or two in the morning. It would also unleash a lot of angry feelings in him which I bore the brunt of. He wasn't physically violent, but he was verbally violent, and occasionally he would smash things.

Frank: In my mother's case, the consequence of her drinking was that we didn't eat very much. We were ill kempt, input into our education from parents was negligible. Discipline was heavy because she used to get very angry so she was very disciplinarian but not in a constructive way. So her choosing to drink actually impacted on my life and my siblings' lives very strongly because of the fact that I didn't have a toothbrush, I didn't have clean clothes, I had no input into my education, no help with homework and things like that. No help with emotional issues around puberty and things like that when you're growing up.

In order to cope with these consequences, participants talked about a variety of strategies that they had developed which ranged from actively attempting to intervene to emotionally withdrawing from the situation:

Denise: It became a game of watching my mum to see when she was going to start drinking again and because I was quite tuned into how she behaved, I would know if she wanted to

do a particular run to the shop and then the game would be to get her not do the run to the shop or to somehow, kind of, prevent her. I suppose it gave me some kind of illusion of control up to a point, like, "Everything's going to be okay if we can just play this part of the game".

Charlie: I think I was quite good at being oblivious as a child, I mean I just cut away. I think it was a defensive reaction. I was, especially as a teenager, a very, very unemotional person. I was absolutely ice cold. I'd go through arguments that had my mum and sister in tears, my dad raging and I'd be, you know, I suppose like an iceberg. Just this little bit on the top and everything else was underneath.

3.2 MAKING SENSE OF ALCOHOL DEPENDENCE: A GROUNDED THEORY

The model shown in Figure 2 represents a grounded theory of the beliefs that participants held concerning the nature of, and responsibility for, alcohol dependence. The core categories, labelled [1] to [6] as in Figure 1, are hypothesised to be linked by propositions which are indicated by arrows [A] to [E]. For ease of reading, sub-categories have not been included in the diagram. It is important to note that the proposed model is based upon the researcher's interpretations of the data and therefore must be treated with caution until subjected to further research.

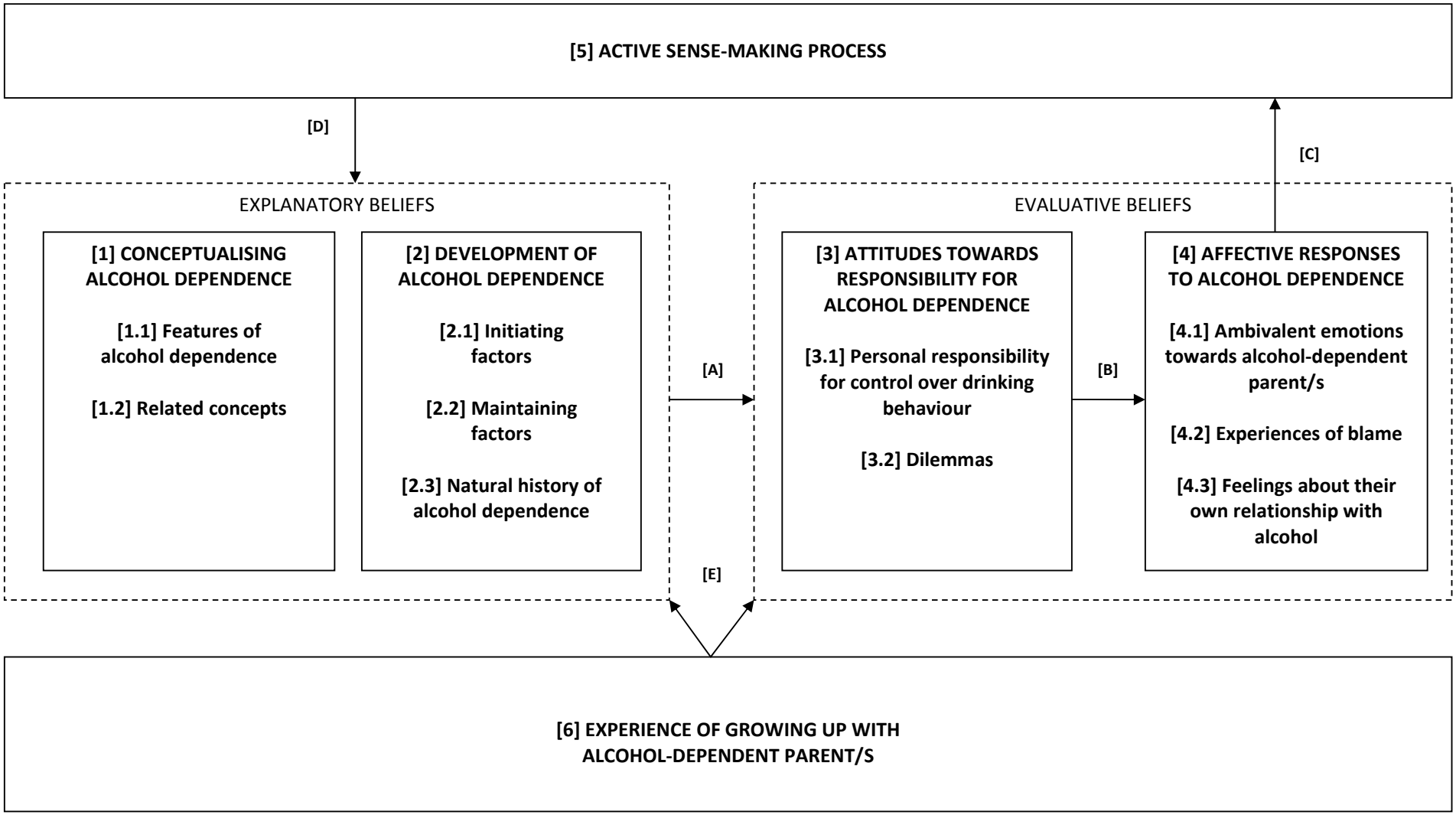
With regard to core categories, the researcher noted that some appeared to cluster into those that were explanatory, i.e. attempts to clarify and/or explain the phenomenon in question, and those that were more evaluative in nature, i.e. concerned with moral stances and/or judgements of like or dislike. It is proposed that core categories 1 and 2 fall within the cluster of explanatory beliefs, in that they predominantly aim to describe what alcohol dependence is and explain how it might come into being. In terms of evaluative beliefs, it is proposed that the participants' attitudes towards the responsibility for alcohol dependence and their affective responses to alcohol dependence fall within this cluster as they are more

concerned with who participants think 'should' be responsible for alcohol dependence and how it makes them feel.

It is hypothesised that:

- [A] Participants' explanatory beliefs affect the type of evaluative beliefs they hold, e.g. if they believe that genetic and neurological changes are major factors in the development of alcohol dependence, then perceived responsibility for control over drinking may be reduced;
- [B] Participants' attitudes towards personal responsibility for alcohol dependence are related to their affective responses, e.g. the more that the participant views the alcohol-dependent individual as being responsible for their drinking behaviour, the less sympathy and more anger towards them they are likely to experience;
- [C] Participants' affective responses towards alcohol dependence influence the degree to which they engage in an active sense-making process, e.g. the more angry the participant feels towards their parent, the less inclined they are to attempt to understand their problematic drinking behaviour;
- [D] The active sense-making process informs participants' explanatory beliefs, e.g. the more that individuals engage in finding out about alcohol dependence, the more highly developed their beliefs become;
- [E] Participants' experiences of growing up with alcohol-dependent parent(s) impact on both their explanatory and evaluative beliefs, e.g. observing a parent recover (or not recover) from alcohol dependence changes individuals' beliefs about chronicity.

Figure 2. A grounded theory regarding the beliefs that participants held concerning the nature of, and responsibility for, alcohol dependence



CHAPTER 4:

DISCUSSION

The closing chapter provides a review of the results presented in the previous chapter (Section 4.1), followed by a discussion of issues regarding reliability and validity that may aid interpretation of the data (Section 4.2). Links are made between the research findings and relevant literature as well as clinical practice (Sections 4.3 and 4.4) and the researcher also makes some suggestions for future research (Section 4.5). Within the final section (4.6), the study is summarised and the researcher outlines the conclusions reached via the research process.

4.1 REVIEW OF RESEARCH FINDINGS

This section provides a discussion of the key issues raised by participants over the course of the interviews, makes links between them and the original research questions and outlines a general statement of theory to summarise the data.

With regard to **CONCEPTUALISING ALCOHOL DEPENDENCE**, participants appeared to identify some unique features but also noted that alcohol dependence may share characteristics with other **related concepts**. Particular **features of alcohol dependence**, included subjective experience of reliance, compulsion, preoccupation and chronicity. It appears that several of these features relate to aspects of alcohol dependence that may be subjectively experienced by the alcohol-dependent individual, and these may or may not be obvious to the observer. This indicates that participants were able to show some

acknowledgement of the alcohol-dependent individual's perspective. In a few cases, participants also used their own experiences of, for example, compulsive behaviours to illustrate and access these subjective feelings. One participant commented on how the 'addiction inside you' operates to compel you to engage in behaviours that you may not want to engage in. Another participant referred to the 'relationship' that her mother had with alcohol which, in the context of alcohol and the family, indicates the salience of alcohol to both the individual and others around them. These ideas suggest that alcohol dependence can involve a struggle between competing interests, in terms of the individual meeting their own life goals and those of their family. There were mixed views with regard to chronicity, i.e. whether alcohol dependence is a short-term or long-term condition. As proposed in the previous chapter, participants' views may have been influenced by their experiences of observing parents' or other individuals' attempts to recover from alcohol dependence.

The researcher noted the absence of reports of 'craving' and 'denial' as possible features of alcohol dependence. Based on her clinical experiences with alcohol-dependent individuals, the researcher expected to encounter these concepts more frequently within the data set. Although craving was mentioned briefly in the context of how it may influence an individual choosing to be active in addiction, and denial was referred to in terms of how it could interfere in the **ACTIVE SENSE-MAKING PROCESS**, these concepts did not emerge as categories in the data. However, it may be that the concept of craving is closely associated with the subjective experience of reliance and compulsion features, or that craving is a term more likely to be used by individuals who have personal experience of alcohol dependence.

In addition, although participants made little reference to denial, they did discuss the issue of awareness of alcohol dependence across the data set. For example, participants noted that awareness may be lacking during the gradual process of developing alcohol dependence, and when discussing the importance of resources for **personal responsibility for control over drinking behaviour**, self-awareness was included as an internal resource.

Overall, the participants appeared to view dependence on other substances as being conceptually similar to dependence on alcohol, although they acknowledged that different addictions may differ in terms of their **initiating factors**. For example, due to differences in its availability, legality and the lack of stigma associated with it, alcohol may be easier to access and to use heavily than illicit drugs. Although initiating factors such as coping with stress may be similar for both alcohol dependence and general drinking behaviour, participants noted that there might be differences between these different drinking patterns. Alcohol dependence was not specified in terms of the quantity of alcohol consumed, but in terms of the quality of the drinking style; for example, alcohol use may be seen as a 'fix' as opposed to merely a 'relaxant' as may be the case with general drinking behaviour. In considering the other negative parental behaviours that may have been observed as part of the **EXPERIENCE OF GROWING UP WITH ALCOHOL-DEPENDENT PARENTS/S**, some participants emphasised that the issue of alcohol dependence was secondary to other pre-existing mental health or personality problems. In this view, alcohol-dependent individuals may be drinking to cope with underlying issues such as depression or bereavement. One participant questioned whether this relationship might be bi-directional,

i.e. that alcohol dependence may also increase mental health difficulties, but appeared uncertain about this association.

When considering the **DEVELOPMENT OF ALCOHOL DEPENDENCE**, participants appeared to subscribe to a multi-factorial model that comprised a number of interacting, biopsychosocial variables. The researcher distinguished between **initiating** and **maintaining factors** as participants had made reference to several causal factors that would generally only have occurred following the development of alcohol dependence; e.g. neurological changes, family's responses and lack of negative consequences. However, it is possible that these categories are not mutually exclusive and it is likely that many of the initiating factors, such as drinking to cope, could be relevant at other stages of alcohol dependence.

The variables most frequently mentioned and explored in greatest depth by participants were drinking to cope and addictive personality. It may be that these factors are linked; for example, people with an addictive personality might be more likely to drink alcohol to cope with life stressors than other people. However, on further scrutiny some participants found the notion of an addictive personality difficult to conceptualise. One participant seemed unsure as to how an addictive personality could be integrated into the rest of an individual's wider personality structure and others did not seem keen to apply the label of addictive personality to individuals. Some participants suggested that genetic explanations may be linked with the addictive personality concept. For example, genetic factors may contribute to particular personality types which may then predispose individuals to being more or less likely to develop alcohol dependence, via individual differences in the rewarding drug

effects of alcohol. Participants also highlighted the significance of contextual influences, such as childhood learning experiences and social pressures, in creating a backdrop within which alcohol use is normalised and which may lead to a lack of negative consequences – at least in the early stages of use. Overall, the **natural history of alcohol dependence** was seen to be a largely non-intentional and gradual process, in that alcohol dependence itself was not necessarily a desired end state for the individual. Participants appeared to suggest that although there may be individual differences in the way that alcohol dependence develops over time, the **features of alcohol dependence** are ultimately similar across individuals.

In their **ATTITUDES TOWARDS RESPONSIBILITY FOR ALCOHOL DEPENDENCE**, the data indicate that **personal responsibility for control over drinking behaviour** was emphasised by the majority of participants. Although contextual factors could contribute to the **DEVELOPMENT OF ALCOHOL DEPENDENCE**, it appeared that participants viewed alcohol-dependent individuals to be responsible for choosing to be active in the addiction. However, it seemed that alcohol-dependent individuals' fluctuating capacity for control over their drinking behaviour could make it difficult for participants to make decisions about degrees of responsibility. The presence of **maintaining factors**, such as neurological changes, were also seen as contributing to **dilemmas** regarding **personal responsibility for control over drinking behaviour** as it seems difficult to hold someone responsible for non-conscious physiological processes that might compromise their ability to make choices. The importance of resources (such as social support, self-awareness and a desire to change) was highlighted by participants as a key variable influencing capacity for control over alcohol use, with the desire to stop drinking being central. The researcher proposes that differences

in access to resources may partially account for some of the individual differences seen in the **DEVELOPMENT OF ALCOHOL DEPENDENCE**.

A number of participants expressed difficulties with the idea of viewing a difficult childhood as a risk factor for later alcohol dependence as their own **EXPERIENCE OF GROWING UP WITH ALCOHOL-DEPENDENT PARENTS/S** had not led to them becoming alcohol-dependent themselves. However, it may be that participants' childhood experiences had heightened their levels of self-awareness over their own alcohol use – a factor that had previously been identified as an important resource for control over drinking behaviour. In their consideration of the various **initiating** and **maintaining factors** that might contribute to the **DEVELOPMENT OF ALCOHOL DEPENDENCE**, participants appeared to be sensitive to the differences between understanding versus excusing behaviour. It might have been that the strength of participants' **AFFECTIVE RESPONSES TO ALCOHOL DEPENDENCE** made it more difficult for some to consider the idea that alcohol-dependent individuals may only be partially responsible for their drinking behaviour.

In terms of the spectrum of **AFFECTIVE RESPONSES TO ALCOHOL DEPENDENCE** described by participants, it appeared that they experienced a range of **ambivalent emotions towards alcohol-dependent parent/s**, for example being caught between anger and sympathy. These feelings could be influenced by a range of moderating factors, such as level of self-awareness or ability to fulfil parental roles. Some of these moderating factors seemed to relate to the **dilemma** regarding degrees of responsibility; for example, one participant felt less angry with his father who had mental health problems than with his mother who was

alcohol-dependent. This may have been because he believed that mental health problems were less controllable than alcohol dependence.

The researcher proposed that participants' **ATTITUDES TOWARDS RESPONSIBILITY FOR ALCOHOL DEPENDENCE** were related to their **AFFECTIVE RESPONSES TO ALCOHOL DEPENDENCE** and therefore any dilemmas that exist regarding responsibility could contribute to the sense of ambivalence expressed by participants.

Participants also described a number of **experiences of blame**, such as parental avoidance of blame, possible benefits of blame and reflections on their own culpability for their parents' alcohol dependence. The concept of blame appeared frequently throughout the entire data set and seemed to comprise both cognitive and affective components; for example, participants outlined some of the ways in which blame could be used to seemingly absolve individuals of responsibility and also modify their mood state. Two participants commented that society as a whole may also participate in this process. In terms of reflections on their own culpability, participants did not seem to blame themselves for their parents' alcohol dependence but had experienced a range of related feelings (e.g. being ashamed of their parent) and negative self-related emotions (e.g. worthlessness, uselessness). Participants also had **feelings about their own relationship with alcohol** and these predominantly related to concerns about risk of developing alcohol dependence themselves. They emphasised the importance of not being like their parent and reported a mixture of feelings of worry and pride about this issue. The researcher proposes that these feelings may have been related to their beliefs about **initiating factors** and **ATTITUDES**

TOWARDS PERSONAL RESPONSIBILITY FOR ALCOHOL DEPENDENCE. For example, if a participant believes that genetic explanations are central to the **DEVELOPMENT OF ALCOHOL DEPENDENCE**, then they may worry about whether they are likely to inherit this predisposition. Alternatively, if a participant subscribes strongly to the idea of personal responsibility for control over drinking behaviour, then they may feel a sense of pride (if they are able to avoid becoming alcohol dependent).

In order to develop and refine their beliefs regarding alcohol dependence, it appeared that the participants had embarked on an **ACTIVE SENSE-MAKING PROCESS**, which for some had initially involved making sense of their parent's negative behaviours followed by the recognition that these were related to their alcohol use. They seemed to have used multiple sources of information, including their own experiences and the NACOA helpline training programme, to piece together an understanding of the nature of alcohol dependence. Similar to the idea that a desire to stop drinking might be necessary for controlling drinking behaviour, it may be that a desire to understand their parent's drinking behaviour was vitally important for these participants' motivation to learn more about alcohol dependence. Participants' levels of motivation to understand their parents' drinking and alcohol dependence in general, may be related to their particular **EXPERIENCE OF GROWING UP WITH ALCOHOL-DEPENDENT PARENTS/S**. The researcher proposes that the nature of the consequences of parental alcohol dependence and the type of coping strategies employed by participants may both influence their level of motivation to understand.

In summary, the research findings indicate that participants had developed a range of interrelated beliefs, attitudes and affective responses regarding alcohol dependence that were elaborated on, via a deliberate process of information-seeking, motivated and influenced by the nature of their childhood experiences of parental alcohol dependence.

4.2 RELIABILITY AND VALIDITY

In order to maximise the reliability and validity of the research findings, the researcher used the guidelines proposed by Elliott and colleagues (1999) as a framework:

- *Owning one's perspective*: throughout the research process, the researcher attempted to recognise how her own values, interests and assumptions might influence data collection and analysis; for example, by maintaining a reflective diary (Appendix I) and including a discussion regarding reflexivity (Chapter 2);
- *Situating the sample*: in Chapter 2, the researcher described the participants and where possible included details about their childhood living circumstances, the identity of their alcohol-dependent parent and their own level of alcohol consumption;
- *Grounding in examples*: the researcher provided excerpts from the raw transcribed data (Chapter 3) and also included examples of the memo-writing (Appendix K) conducted to illustrate the analytic procedures used in the study and the emerging interpretations of the data;
- *Providing credibility checks*: the interview transcripts were shared with the researcher's clinical supervisor, and during two subsequent meetings, both the

clinical and academic supervisors checked the coherence and plausibility of the emergent grounded theory. The core categories and corresponding categories/sub-categories were also presented to the Director of NACOA and the feedback from this meeting was taken into account during the process of developing the final grounded theory model. In addition, participants were invited to comment on the data analysis via email communication. Two participants responded:

Beth: I just had a look through the results and yes I really feel that the analysis fits totally with my own experience and it is strangely nice to see that the other experiences are also quite similar and the feelings and confusions are also expressed by other individuals. I think I can pick out myself and it is weird reading back what I said but in a good way; you do tend to forget some things until you relive them again.

Anna: It was very interesting to read the research. I think the thing which struck me the most was that my dad's problem with alcohol was really a secondary thing to my problems with his personality. This was probably because as a family we never ever identified his drinking, never talked about it. So that by the time my mother finally started talking about him in terms of being an alcoholic I just wanted to be as far away from him as possible, because he was him, not necessarily because he was an alcoholic. I suppose what I mean is that I never separated the two aspects of him and therefore never thought of his drinking as a problem in itself, just part of him, who in himself was the problem. I don't know if that makes any sense but it was the thing that struck me as different to the responses of the other participants.

- *Accomplishing general versus specific research tasks*: the research aimed to explore the beliefs that people who have experienced parental alcohol dependence during childhood hold regarding the nature of and responsibility for alcohol dependence, the possible relationships between such beliefs and their own alcohol use and the possible relationships between such beliefs and feelings of guilt, shame and blame. It is believed that the data collection and analysis process reflects and has accomplished these aims. With regard to more general research tasks, the researcher referred to Spencer and colleagues' (2003) guiding principles, which state

that as well as being reliable and valid, qualitative research should be contributory in advancing wider knowledge or understanding about policy, practice or theory. Sections 4.3 and 4.4 of this chapter aim to address the possible theoretical and clinical implications of the current research findings;

- *Coherence* and *resonance with readers*: the researcher has received positive feedback from readers with regard to the draft versions of this report and it is hoped that the research findings have been presented in such a way that future readers will judge it to have represented accurately the subject matter and to have expanded their appreciation and understanding of it.

Although a range of measures were employed to enhance the reliability and validity of the research findings, there are also a number of methodological limitations worth noting. In terms of sampling issues, since the participants were not part of a clearly defined clinical population (but related to one), recruitment may have proved difficult if the research had not been conducted in association with NACOA. However, this meant that the participants were a specific sub-population of COAs who had made contact with an organisation in order to access information, advice and support about their situation. Many of the participants (eight of the ten) had also attended the NACOA helpline training programme which includes modules on addiction, the concept of co-dependency, family dynamics and abuse. When discussing the results with the Director of NACOA, she mentioned that during the training there is an emphasis on directing blame away from callers for their parents' alcohol dependence. This may partly explain the strong emergence of the category regarding the need for individuals to take **personal responsibility for control over drinking behaviour**.

The CAST screening instrument was used to corroborate participants' COA status and is a frequently used tool within the literature (Vail *et al*., 2000), although in retrospect the researcher believes that self-report alone may have been sufficient. The recruitment pathway via NACOA is likely to have acted as a screening process in itself.

With regard to the role of the researcher in the interpretation of the data, it is likely that existing theories, in particular work by Weiner (e.g. 2000), played a role in the grounded theory that emerged. However, the researcher made use of a range of techniques, such as constant comparative analysis and negative case analysis, in order to ensure that the resultant categories were grounded in the data as far as possible.

4.3 THEORETICAL CONSIDERATIONS

4.3.1 Concept of alcohol dependence

In conceptualising alcohol dependence, participants highlighted a number of features that seem to be consistent with Edwards and Gross' (1976) provisional description of the clinical syndrome. For example, the subjective experience of reliance and compulsion categories appear to relate to the 'subjective awareness of compulsion to drink' element. In addition, the 'narrowing of the drinking repertoire' and 'salience of drink-seeking behaviour' elements may relate to the feature of preoccupation with drinking. Although participants did not use the terms 'tolerance' or 'withdrawal', they seemed to make indirect references to these concepts; for example, by suggesting that alcohol-dependent individuals might 'feel

out of kilter' without alcohol and that neurological changes may mean that the 'brain gets used to' alcohol. In terms of 'reinstatement of drinking after abstinence', some participants did note that recovery may not be a simple case of 'go to rehab once, then come out and everything's fine'. The ICD-10 classification system also defines other categories of substance use, such as 'acute intoxication' and 'harmful use' which is consistent with participants making links with the **related concepts** regarding drinking behaviour.

4.3.2 Previous research on COAs

The results of the current study provide tentative support for a number of findings from the wider literature regarding COAs. For example, the core category concerning the **EXPERIENCE OF GROWING UP WITH ALCOHOL-DEPENDENT PARENT/S** seems to be consistent with previous research concerning the impact of parental alcohol dependence on family life (e.g. Velleman, 1993) and also the types of coping strategies employed by family members (e.g. Orford, 1992). The present research extends the qualitative literature on COAs by exploring their beliefs and attitudes towards the nature of alcohol dependence and how these understandings might relate to beliefs about their own risk status and affective responses to alcohol dependence.

Participants' beliefs about self-medication suggests that they may hold some positive expectancies about the effects of alcohol (e.g. it can be a relaxant) as found previously (Lundahl *et al*., 1997) but simultaneously maintain negative expectancies about the state of alcohol dependence (e.g. it can be damaging to individuals and their families). The data also indicate that participants may be aware of exhibiting higher levels of preoccupation with

control over drinking than their peers, which has been found previously (e.g. Chassin & Barrera, 1993). In addition, the literature regarding resilience in children affected by parental substance misuse suggests that 'deliberate planning by the child that their adult life will be different' is an indicator of positive outcomes (Velleman & Templeton, 2007). Participants in the current study emphasised the importance of not being like their parent, which indicates that they may have been a particularly resilient group of COAs, which may in part be associated with their seeking contact with and receiving support from NACOA.

4.3.3 Theories regarding attribution

When considering the various causes for alcohol dependence, participants made attributions based on both situational and dispositional factors, although there seemed to be an emphasis on dispositional factors. For example, although alcohol-dependent individuals may be drinking in response to various stressors in the environment, their choice of coping strategy may be driven by intrinsic factors such as having an addictive personality.

This tendency for participants to privilege dispositional factors relative to situational factors may be linked with their motivation to make particular attributions based on past experiences. Kelley (1980) proposed that 'self-serving biases' may determine whether individuals have an 'open-ended' or 'preoccupied' attributional style. A number of participants reflected on the **dilemmas** they experienced regarding whether understanding an alcohol-dependent individual's drinking behaviour would lead to them being 'let off the hook'. This may have led some participants to over-value dispositional explanations in comparison with situational factors.

Weiner's (1986; 2000) work on the emotional responses that might follow from particular attributional profiles is relevant to the hypotheses proposed by the researcher; i.e. that if responsibility for drinking behaviour is attributed to an internal, controllable cause, then continued alcohol dependence is likely to lead to feelings of anger. Since participants specified a number of different causal factors, which varied in terms of their locus, controllability and stability, their affective responses and attitudes would be expected to be ambivalent and fraught with dilemmas.

4.4 CLINICAL IMPLICATIONS

Based on the research findings, a number of implications for clinical practice were identified. Within specialist drug and alcohol services, service provision for family members is currently limited (Templeton *et al*., 2007) even though the National Treatment Agency (2006) recommends that alcohol treatment services have a role to play in the provision of services to 'those affected by someone else's drinking'. A manualised brief intervention, developed by Copello and colleagues (2000), comprises five elements: giving the family member the opportunity to talk about the problem, providing relevant information, exploring coping strategies, enhancing social support and a consideration of the possibilities for onward referral for further help and support. The data from the present study could be used to help clinicians decide what information might be useful to provide family members with; for example, not only about what alcohol dependence is, but about some of the issues regarding responsibility, ambivalent emotions and experiences of blame.

There may also be a number of training needs for staff members within drug and alcohol services about the experiences of growing up with an alcohol-dependent parent and the dilemmas that children living in such families may be faced with. The issue of inter-generational transmission seemed to be a significant concern for participants in this study and therefore it would be useful for services to consider how this issue might best be tackled with families. This could be via the development of materials, such as the 'Rory' storybook, a learning resource that tackles the issue of harm caused to children because of parental alcohol problems (Alcohol Focus Scotland, 2007). Through initiatives such as this, both supportive and preventative work may be delivered to families and communities.

4.5 RECOMMENDATIONS FOR FUTURE RESEARCH

The research findings have provided insights into the types of beliefs held by a specific sub-population of COAs regarding the nature of alcohol dependence. It would be of interest to conduct similar qualitative research with other populations, such as COAs with a history of alcohol dependence or individuals who have not been affected by parental alcohol dependence. This would allow further exploration of the grounded theory structure developed in this study. In addition, the majority of research participants in this study were females in their early to mid-adulthood who described their ethnicity as 'white'. Since Kingree and Thompson (2000) found a higher level of parental blame among females, the inclusion of participants with a broader demographic range may permit closer examination of the similarities and differences between groups.

In Chapter 3, a number of hypotheses were proposed and the researcher believes that both quantitative and qualitative methodologies may be used to address these. For example, the proposition that the more angry an individual feels towards their parent, the less inclined they are to attempt to understand their problematic drinking behaviour could be investigated using a quantitative design; for example via a questionnaire study.

4.6 SUMMARY AND CONCLUSIONS

The current study employed a qualitative methodology to explore the beliefs held by individuals affected by parental alcohol dependence regarding the nature of, and responsibility for, alcohol dependence. The findings revealed that through an active sense-making process, participants had developed a wide range of beliefs regarding the concept of alcohol dependence and its development. They also held a number of attitudes towards the responsibility for alcohol dependence and experienced a variety of dilemmas and ambivalent emotions relating to these. It is hoped that the current results will add to the current literature regarding COAs and contribute to clinical practice, so that the needs of families affected by alcohol dependence may be better met.

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LIST OF APPENDICES

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Appendix B Letters regarding ethical approval

Appendix C Supporting letter from the National Association for Children of Alcohol-dependent Parents

Appendix D Letter of invitation

Appendix E Participant information sheet

Appendix F Telephone screening demographics questionnaire

Appendix G Children of Alcoholics Screening Test-6 (CAST-6; Jones, 1994)

Appendix H Consent form

Appendix I Excerpt from reflective diary

Appendix J Excerpt from interview transcript

Appendix K Excerpt from summary memos

Appendix L Excerpt from notes regarding emergent themes

Appendix M N-VIVO codes

Interview schedule

"Understanding addiction: exploring beliefs held by people affected by parental alcohol dependence"

Researcher: Jessica Zetteler, Trainee Clinical Psychologist

Outline interview questions:

WHAT are your ideas ...

1. ***What sort of things cause people to become addicted to alcohol?***
   - *In what way do you think people are responsible for their own drinking?*
   - *In what way do you think that other people are responsible for someone's drinking?*
   - *In what way do you think that circumstances are responsible for someone's drinking?*
2. ***What sort of things help people recover from being addicted to alcohol?***

HOW did they develop ...

3. ***To what extent have your ideas about addiction changed over time?***
   - *To what extent have your views about the nature of addiction been influenced by your parents?*
   - *To what extent have your views about the nature of addiction been influenced by people other than your parents?*

HOW do they affect your feelings and behaviour ...

4. ***In what way have your ideas about addiction affected your own drinking behaviour?***
5. ***How might your ideas about addiction affect the way you feel about your parents drinking behaviour?***
   - *angry?*
   - *embarrassed or ashamed?*
   - *responsible or guilty?*
6. ***How might your ideas about addiction affect the way you would go about helping someone with a drink problem?***

Canolfan Gwasanaethau Busnes
Business Services Centre

South East Wales Research Ethics Committee Panel C

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Miss Jessica I Zetteler
Trainee Clinical Psychologist
Cardiff and Vale NHS Trust
South Wales Doctoral Programme in
Clinical Psychology, Archway House,
77 Ty Glas Avenue, Cardiff
CF14 5DX

21 September 2008

Dear Miss Zetteler

Full title of study: **Understanding addiction: exploring beliefs held by people affected by parental alcohol dependence**

REC reference number: **08/WSE03/43**

The Research Ethics Committee reviewed the above application at the meeting held on 19 September 2008.

Thank you for attending to discuss the study.

Ethical opinion

The Committee noted that this was a multi-site study involving qualitative methods only, which aimed to explore the beliefs that people who had experienced parental alcohol dependence during childhood hold regarding the nature of alcohol dependence.

The Committee noted that the study was sponsored by the Cardiff & Vale NHS Trust and that therefore NHS indemnity applied.

The Committee noted that the sponsor's representative had declared that an appropriate process of scientific critique had demonstrated that this research proposal was worthwhile and of high scientific quality.

The Committee noted that the study had been approved by the Joint Trust/University Peer & Risk Review Committee.

The Committee noted that the study was being undertaken as an educational project in part fulfillment of a PhD and would involve twelve male and female participants over the age of 18, none of whom would be unable to consent for themselves through physical or mental incapacity.

The Committee noted that participants would be recruited via the National Association for Children of Alcoholics (NACOA), with a letter of invitation being sent by the Director of NACOA to individuals who had previously given consent to be contacted regarding research. The Committee further noted a letter dated the 14 August 2008, from the Director of NACOA confirming support for the research.

The Committee noted that participants would be subject to non-clinical research related intervention or procedures.

The Committee noted that the expected total duration in the study for each participant was approximately two and a half hours over a six month period.

The Committee noted that research participants would be offered reimbursement of any travel expenses incurred as a result of taking part in the study, and further noted that potential participants were not informed of this within either the *Letter of Invitation* or the *Information Sheet*.

The Committee agreed that although the *Information Sheet* did not fully comply with the NRES recommended template for such documents, it was nevertheless appropriate in the circumstances of this particular study.

The Committee noted that the study raised the potential of causing distress to participants and were this to occur then details of the NACOA helpline would be provided.

The Committee noted that informed consent would be obtained from the research participants and that a signed record of consent would be obtained.

The Committee noted that participants would have a minimum of one week in which to decide whether or not to take part in the study.

The Committee noted from *Section A30-1* of the *Application Form*, that if a participant who had given informed consent subsequently lost capacity to consent during the study, then that participant would be withdrawn.

The Committee further noted that data which was not identifiable might be retained. Any identifiable data collected with consent would be disposed of.

The Committee noted the assurance provided within the application that all data relating to participants would be held and processed in the strictest confidence and in accordance with the Data Protection Act (1998) and the NHS Confidentiality Code of Practice (2003).

The Committee in noting that data would be stored on laptop computers strongly advised that the data be protected by a suitable encryption programme.

The Committee pointed out that it was the responsibility of the Chief Investigator to be up to date and to comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA).

There is no need to submit the Site-Specific Information Form to any Research Ethics Committee.

The favourable opinion for the study applies to all sites involved in the research.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

1 **The Information Sheet must be revised to advise that participants would be reimbursed traveling expenses incurred as a result of taking part in the study.**

2 **The reference to *"medical care"* in the section of the Information Sheet headed *"Do I have to take part"* must be removed.**

3. **The reference to *"medical care"* in point 2 of the Consent Form must be removed.**

4. **The Consent Form must include in point 1 the version number and date of the associated Information Sheet.**

5. **Once the above changes have been made to the Information Sheet and Consent Form, copies of the final versions of both documents must be provided for the REC file.**

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Application	1.1	28 August 2008
Investigator CV	N Frude	19 August 2008
Investigator CV	A Smith	21 August 2008
Investigator CV	J Zetteler	13 August 2008
Protocol	4	24 July 2008
Peer Review	Joint Trust/University Peer & Risk Review Committee	12 August 2008
Interview Schedules/Topic Guides	2	14 August 2008
Questionnaire: CAST-6		04 July 2008
Questionnaire: Demographic Questionnaire	2	04 July 2008
Letter of invitation to participant	2	20 July 2008
Participant Information Sheet	3	20 July 2008
Participant Consent Form	3	20 July 2008
NACOA letter of support	H Henriques	14 August 2008
NACOA Insurance		23 September 2007

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/WSE03/43 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Mrs J Jenkins
Chair, Panel C
South East Wales Research Ethics Committees
(Dictated but not signed)

Enclosures: List of names and professions of members who were present at the meeting

SL-AR2 for other studies

Copy to: R&D Department for Cardiff & Vale NHS Trust

South East Wales Research Ethics Committee Panel C

Attendance at Committee meeting on 19 September 2008

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr R Al Samsam	Consultant Paediatric Intensive Care	Yes	
Dr D Alldrick	Consultant Psychiatrist for the Elderly	No	
Mrs J Darmanin	Nurse	Yes	
Mrs J Evans	Consultant Obstetrician & Gynaecologist	Yes	
Mrs Kathy Fisher	Lay	Yes	
Mrs M Hedley-Clarke	Lay Member	Yes	
Mrs J Jenkins	Chair and Lay Member	Yes	
Dr S M Jenkins	Consultant (Senior Lecturer)	No	
Mr T J Morgan	Lay Member	Yes	
Dr B Patel	GP	Yes	
Mrs Janice Rees	Consultant Clinical Psychologist	Yes	
Dr Tei Sheraton	Consultant Anaesthetist	No	

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13 October 2008

Miss Jessica I Zetteler
Trainee Clinical Psychologist
1st Floor, Archway House
77 Ty Glas Avenue
Llanishen, Cardiff
CF14 5DX

Dear Miss Zetteler

REC reference number: 08/WSE03/43 - Understanding addiction: exploring beliefs held by people affected by parental alcohol dependence
Investigator: Miss Jessica I Zetteler, Trainee Clinical Psychologist, Cardiff and Vale NHS Trust, South Wales Doctoral Programme in Clinical Psychology

Thank you for your letter of the 10 October 2008, with regard to the above study.

I acknowledge receipt of the revised participant information sheet (version v.4, dated 10/10/08), consent form (version v.4, dated 10/10/08) and confirm that a copy has been placed on file.

Thank you for your prompt response and good luck with your study.

Yours sincerely

Mrs Jagjit Sidhu
Research Ethics Committee
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NHS WALES GIG CYMRU

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From: Professor MF Scanlon
Trust R&D Director
Radnor House
University Hospital of Wales
Cardiff
CF14 4XW

12 August 2008

Professor Neil Frude
South Wales Doctoral Programme In Clinical Psychology
Archway House, 77 Ty Glas Avenue
Llanishen
Cardiff
CF14 5DX

Dear Professor Frude

Project ID : 08/MEH/4345 : Understanding Addiction: Exploring Beliefs Held By People Affected By Parental Alcohol Dependence

Thank you for your recent communication regarding the above project, which was reviewed on 12 August 2008 by the Chair of the Joint Trust/University Peer & Risk Review Committee.

I am pleased to inform you that the project has been approved and that Cardiff and Vale NHS Trust will act as research Sponsor under the Research Governance Framework for Health and Social Care. The Trust is therefore happy for the project to begin, subject to:

1) Approval from the appropriate NHS Research Ethics Committee
2) Honorary Contracts, where required, being in place before the research begins.

Please ensure that the appropriate Research Ethics Committee have a copy of this letter. Once you have gained ethical approval, please forward a copy of the approval letter to the Research and Development Office at the above address.

May I take this opportunity to wish you success with the project and remind you that as Principal Investigator you are required to:

POSITIVE ABOUT DISABLED PEOPLE

- Inform the Trust R&D Office if any external or additional funding is awarded for this project in the future.
- Inform the Trust R&D Office of any amendments relating to the protocol, including personnel changes and amendments to the actual or anticipated start / end dates.
- Complete any documentation sent to you by the Trust R & D Office or University Research & Commercial Division regarding this project.
- Ensure that adverse event reporting is in accordance with Cardiff and Vale NHS Trust Policy and Procedure for Reporting Research-Related Adverse Events (Refs 164 & 174) and the Trust Incident Reporting and Investigation Procedure (Ref 108).
- Undertake the project in accordance with ICH-GCP.
- Adhere to the protocol as approved by the Research Ethics Committee.
- Ensure the research complies with the Data Protection Act 1998.

Yours sincerely,

pp **Professor MF Scanlon**
Chair of the Joint Trust/University Peer & Risk Review Committee

CC **R&D Lead Dr Pamela Roberts**
Miss Jessica Zetteler

[ENCS] Obtaining a Sponsor Signature – Guidelines

C:\my documents\lisa\databases\study folders\4345\RD Letters\08-MEH-4345 Chairmans Decision Approval Letter 12-08-2008.doc

THE NATIONAL ASSOCIATION FOR CHILDREN OF ALCOHOLICS

Patrons: Mr Tony Adams MBE, Ms Geraldine James OBE, Mr Fergal Keane OBE
Ms Elle Macpherson, Dr D Samways MB BS, Mrs S Stafford-Nolan CQSW

Dear Jessica,

Re: Understanding addiction: exploring beliefs held by people affected by parental alcohol dependence.

Thank you for asking for the support of NACOA in your research project. We would be delighted to provide you with this support.

The support we will provide will take the form of assistance in the recruitment of participants, and the provision of space on our premises where you will be able to interview participants in your study in a safe environment.

We are delighted to be able to support such important research, and are very interested in hearing about your findings and publishing these on our website.

Good luck with your research.

Yours sincerely,

Hilary Henriques MBE

PO Box 64, Fishponds, Bristol BS16 2UH Tel: 0117 924 8005 Fax: 0117-942 2928
Helpline: 0800 358 3456 helpline@nacoa.org.uk
Email: admin@nacoa.org.uk **Website:** www.nacoa.org.uk

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Ms Elle Macpherson, Dr D Samways MB BS, Mrs S Stafford-Nolan CQSW

LETTER OF INVITATION

Understanding addiction: exploring beliefs held by people affected by parental alcohol dependence

Jessica Zetteler

You are being invited to take part in a research study because you have expressed an interest in studies of this kind. You do not have to take part in the study if you do not want to.

The study aims to explore some of the thoughts and feelings that adults who grew up with parents who were dependent on alcohol might have experienced. Participants would be required to take part in an audio-taped interview which is estimated to last between one and two hours.

If you are interested in taking part in this particular study, I can send you a full information sheet, and then contact you to arrange an appointment if you are still interested in continuing.

Who has reviewed the study?

The South East Wales Research Ethics Committee have reviewed and approved the study (08/WSE03/43).

Who can I contact for further information?

For further queries, and for an information sheet, please contact Jessica Zetteler at the South Wales Doctoral Programme in Clinical Psychology, Archway House, 77 Ty Glas Avenue, Llanishen, Cardiff, CF14 5DX. Telephone: 02920 206464 or email: ZettelerJI@cardiff.ac.uk.

SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

PARTICIPANT INFORMATION SHEET

Understanding addiction: exploring beliefs held by people affected by parental alcohol dependence

Jessica Zetteler

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part and remember that your participation is voluntary.

What is the purpose of the research study?

The present study aims to explore some of the thoughts and feelings that adults who grew up with parents who were dependent on alcohol might have experienced. The research literature regarding 'adult children of alcoholics' has found that while some individuals may go on to experience problems with alcohol use, there are also others who do not. The reasons for these different outcomes are not yet clear and it is possible that the alcohol-related beliefs held by people may play a role. The current study hopes to provide a rich initial examination of the key issues which may then lead to further research.

Why have I been invited?

You have been chosen since you expressed an interest in taking part in research studies via the National Association for Children of Alcoholics (NACOA) and requested further information following the earlier letter of invitation. Participants will be selected for interview on the basis that they are aged 18 or over, have experience of parental alcohol dependence during childhood and have not been alcohol-dependent themselves.

What does the research study involve?

If, after you have read the information sheet, you are willing to participate in the research study then please contact Jessica Zetteler (contact details given below) who will arrange a convenient time for a brief telephone call prior to possibly meeting for an interview. During this telephone call, Jessica will ask you some very general questions about yourself (for example, your age) and also some more specific questions about your own and your parents' drinking behaviour. If both yourself and Jessica are happy to proceed to the interview stage, then you will be asked to select a date and venue (either Archway House in Cardiff or the NACOA offices in Bristol) for this. The interview will be audio-taped and is estimated that it will last for around an hour to two hours. You will be asked about your views regarding the nature of addiction and how these might relate to your own drinking behaviour. Following the interview, you will be given the opportunity to comment on a summary of the findings before the final report is written. Any travel expenses incurred as a result of taking part in the study will be reimbursed.

Do I have to take part?

Your participation in the study would be entirely voluntary and you would be free to withdraw at any time without giving any reason, without your legal rights being affected. If you participate in this study you will be given a signed consent form to keep.

What are the possible disadvantages and risks of taking part?

It is not expected that there will be any disadvantages or risks involved in taking part in this study. However, some of the questions will ask you about personal experiences and feelings and it is possible that participants may find some questions uncomfortable to answer. Therefore, time for de-briefing will be provided after each session should any issues that cause distress arise during the interview.

What are the possible benefits of taking part?

It is not expected that you will directly benefit from taking part in this research although the information obtained from this study may help us to better understand the experiences faced by people who have been affected by parental alcohol dependence.

What if there is a problem?

If you wish to complain or have any concerns about any aspect of the way you've been approached or treated during the course of this study, please contact either Jessica Zetteler or Professor Neil Frude (at the address given below) or Ms Hilary Henriques, Director of NACOA, at PO Box 64, Fishponds, Bristol BS16 2UH.

Will my taking part in the study be kept confidential?

Any personally identifiable information produced for this study will remain strictly confidential and will be available only to university research staff or health trust staff directly involved in conducting or supervising the project. The research findings will become publicly available but in an anonymised form, so that it will not be possible for anyone to identify you from any aspect of the documentation or reporting of this research study.

Who is organising and funding the research?

The study is being organised by Jessica Zetteler who is a Trainee Clinical Psychologist employed by Cardiff and Vale NHS Trust. There are no external bodies funding this research.

What will happen to the results of the research study?

When the study has been completed, Jessica will analyse the data and report the findings. These will be submitted to Cardiff University as a doctoral thesis and may later be published in a scientific journal. You will not be identified in any way and if you would like a copy of the final paper or a summary of the main findings, you may request this. If you wish to withdraw your data, you may do this by quoting the participant number that you will be given at the start of the interview. Audio-tape recorded information will be destroyed immediately after completion of the study and any other research documentation will be destroyed three years following completion of the study.

Who has reviewed the study?

The South East Wales Research Ethics Committee have reviewed and approved the study (08/WSE03/43).

Who can I contact for further information?

For further queries regarding the study, please contact Jessica Zetteler at the South Wales Doctoral Programme in Clinical Psychology, Archway House, 77 Ty Glas Avenue, Llanishen, Cardiff, CF14 5DX. Telephone: 02920 206464 or email: ZettelerJI@cardiff.ac.uk.

Date of initial telephone contact: _____

Demographic questionnaire to be completed by researcher during initial telephone contact

1. **Age**: _____ years old

2. **Gender**: ☐ Male
   ☐ Female

3. **Ethnicity** (self-defined): _____

4. **ICD-10 criteria for the alcohol dependence syndrome (use as guideline)**:

Three or more of the following manifestations should have occurred together for at least one month or, if persisting for periods of less than one month, should have occurred together repeatedly within a 12-month period.

- a strong desire or sense of compulsion to consume alcohol;
- impaired capacity to control drinking in terms of its onset, termination, or levels of use, as evidenced by:
  - alcohol being often taken in larger amounts or over a longer period than intended; or
  - by a persistent desire to or unsuccessful efforts to reduce or control alcohol use;
- a physiological withdrawal state when alcohol is reduced or ceased, as evidenced by:
  - the characteristic withdrawal syndrome for alcohol, or
  - by use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- evidence of tolerance to the effects of alcohol, such that:
  - there is a need for significantly increased amounts of alcohol to achieve intoxication or
  - the desired effect, or a markedly diminished effect with continued use of the same amount of alcohol;
- preoccupation with alcohol, as manifested by:
  - important alternative pleasures or interests being given up or reduced because of drinking; or
  - a great deal of time being spent in activities necessary to obtain, take, or recover from the effects of alcohol;
- persistent alcohol use despite clear evidence of harmful consequences, as evidenced by continued use when the individual is actually aware, or may be expected to be aware, of the nature and extent of harm.

5. **Children of Alcoholics Screening Test-6 (CAST-6): see separate sheet**

Eligible for interview: ☐ Y ☐ N

Date of initial telephone contact: _____

CAST-6 questionnaire to be completed by researcher during initial telephone contact

Children of Alcoholics Screening Test-6 (CAST-6; Jones, 1994):

Have you ever thought that one of your parents had a drinking problem?	☐ Y	☐ N
Did you ever encourage one of your parents to quit drinking?	☐ Y	☐ N
Did you ever argue or fight with a parent when he or she was drinking?	☐ Y	☐ N
Did you ever hear your parents fight when one of them was drunk?	☐ Y	☐ N
Did you ever feel like hiding or emptying a parent's bottle of liquor?	☐ Y	☐ N
Did you ever wish that a parent would stop drinking?	☐ Y	☐ N

Participant identification number:

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CONSENT FORM

Understanding addiction: exploring beliefs held by people affected by parental alcohol dependence

Jessica Zetteler

Please initial box

1. I confirm that I have read and understand the information sheet dated 10th October 2008 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐
3. I understand that the interview will be audio-tape recorded and that the tape recording will be kept confidential. I understand that the tape recording will be destroyed immediately following completion of the study. ☐
4. I understand that anonymised data collected during the study may be made publicly available and I give permission for this to happen. I understand that all research documentation will be destroyed three years following completion of the study. ☐
5. I agree to take part in the above study. ☐

Name of participant	Signature	Date
Name of researcher	Signature	Date

CARDIFF UNIVERSITY PRIFYSGOL CAERDYDD

1st Floor, Archway House 77 Ty Glas Avenue Llanishen Cardiff CF14 5DX
Ty Archway, 77 Ty Glas Avenue, Llanishen, Caerdydd CF14 5DX
Tel/Ffon 029 2020 6464 Fax/Ffacs 029 2019 0106

NHS CYMRU WALES

Copies: x1 to participant; x1 to researcher

REFLECTIVE DIARY (typed excerpt)

12.11.2008

I'm feeling quite elated and relieved today as my first interview is now done – really pleased that they are now finally underway! It wasn't quite what I had expected as I found it a little more difficult to stay on track with the interview questions than I had imagined after doing my practice interview with Marcus. It seemed as though the participant was less interested in discussing the nature of alcohol dependence than describing the way that her father's drinking had impacted on her life. I guess it's all useful information but I might need to be better at bringing the conversation back to the original topics in subsequent interviews. This is reminding me of when I was a Research Assistant at the Psychiatry Department and was conducting qualitative interviews. I remember being surprised at how much skill was required to keep them focused. Today I was also reminded about just how tough it can be for people when they're growing up with alcohol-dependent parents. From working with NACOA for coming up to ten years now, it's oddly easy to switch your attention to other issues like policy and organisational matters (especially when you're a trustee and are not working on the helpline anymore). This might turn out to be a bit more challenging than I first thought ...

26.11.2008

I'm starting to feel more confident about the interviews now – the last two have been really interesting and my mind was just buzzing after each one. It's fascinating how different people approach the same subject matter. One of the interviews in particular seemed to have an almost philosophical vibe about it – the participant's analysis of alcohol dependence seemed to tap into core dilemmas about what it is to be human, what it is to make choices, who truly controls our behaviour etc. Clearly he had spent many years thinking about these issues. It was fab and is making me think of the soul-searching and theory-generating phase I went through after my dad left our family. I guess some people respond to difficult life events by thinking about them as much as possible and trying to find answers, whereas others just try to shut it out. And of course there are no doubt lots of shades of grey in between these two extremes. There are some vague ideas starting to form in my mind about how the data is shaping up but I want to stay as open as possible to new avenues of thought! I'm noticing that there is a lot of uncertainty in the participants' responses – they have a range of beliefs but seem to be caught in a struggle between them, e.g. to feel sorry for their parent or feel bitterly angry/disappointed with them. I'm so impressed at how they are able to articulate these predicaments though.

06.12.2008

Half-way through the interviews now! In the last one I noticed that I was doing more talking than I've done before and I cannot decide whether this is a good thing or a bad thing (maybe I should just stop judging it?). I think I am testing out some of the emerging themes, like this issue of how understanding someone's alcohol dependence doesn't necessarily mean that you are excusing it. I know that Grounded Theory allows modification of the interview schedule but it's difficult to know when you are just presenting an idea to a participant and when you are actually influencing the data. I guess it's just something I need to be mindful of. The Compassionate Mind Training that I completed last week has really helped me develop my ideas about shame/blame etc. and their impacts on our behaviour.

INT: Interviewer

RES: Respondent

INT: Okay, so if we just make a start and erm and start thinking about some of the ideas that you have about the nature of alcohol dependence ... what your understanding of it is. What do you think causes someone to become addicted, or leads them to become dependent on something like alcohol?

RES: Erm, for me erm what I think is... sometimes it can be... I suppose there's not one; I don't think there's actually one cause. I don't think it's actually one unique thing.

INT: No.

RES: In some cases it could be because of people feeling distressed, what people call "self-medication", in that they don't feel very happy with their life so they take a swig of beer or some sort of substance and that makes them feel better. And the next one makes them feel a bit better.

INT: Yeah.

RES: And that's when I think a chemical dependency develops ... where your brain gets used to that chemical, and almost a chemical starts substituting your own chemicals in your brain.

INT: Yeah.

RES: So... I feel in that case it's actually a case of self-medication, looking after themselves. A reaction to some sort of distress. But I do think there's an element of addiction that is possibly err quite a, I suppose a selfish thing; I think there is a selfish element to it.

INT: Hmm hmm.

RES: Some people do start drinking, not perhaps to self-medicate, but just to get, if you pardon the expression, pissed. Like they're getting pissed, and then the effect of the alcohol starts waning, so they need to drink more and more as they go along. And eventually once again they develop a chemical dependency.

INT: Yeah.

RES: But the hardest addiction I always find hard to get used to is drugs. Particularly the injecting drugs because I just cannot see why anybody would want to stick a needle in the arm and take something. I mean that's something that has perhaps got a selfish element to it.

INT: Okay.

RES: A selfish form of addiction that they're doing something for very egocentric reasons but then once they get addicted starts having a bad effect on everybody else.

INT: Hmm.

RES: So I think it's a mixture of reasons why people become addicts.

SUMMARY MEMOS (typed excerpt)

Interview 1

- Participants' experience of parent's alcohol use remained unexplored for many years: only recently begun to think about the nature of addiction
- Participant described a 'shutting off' process that helped her avoid disappointment which may have delayed or hindered development of explanations/ideas
- Locating responsibility mainly within parent but alluded to role of others, e.g. issues regarding 'enabling' by other parent and also wider drinking culture of the family and society
- Importance of motivation to explain parental alcohol dependence; participant seemed more concerned with distancing herself from parent rather than understanding his drinking behaviour
- Role of strong emotions (such as anger and disgust) in the process of understanding the alcohol-dependent person's behaviour
- Usefulness of organisations like NACOA in disseminating information about addiction and the experience of living in an 'alcoholic family'

Interview 2

- Participant seemed more motivated to consider why their parent had drunk alcohol than the previous participant
- Nature-nurture debate; difficulties regarding to what extent each factor might play a role in the development of alcohol dependence
- Concept of the 'potential for addiction' residing within a person and then being expressed or not expressed in a particular environment
- Theories re: addiction seemed to apply to all people and across all substances
- Centrality of understanding someone's behaviour versus excusing their behaviour and how this can be difficult to explain to other people who may assume that your intellectual understanding means that you have reached a point of forgiveness
- Ambivalence between entirely personal responsibility and role of external factors
- Importance of idea of personal responsibility for own empowerment and sense of control

Interview 3

- Very philosophical, detached approach to analysing concept of addiction: possible avoidance of painful emotional issues?
- Previously adaptive coping behaviours (such as withdrawal) have become less adaptive
- Participant described how topic of addiction taps into core human condition issues such as who controls our behaviour and who is responsible for solving problems
- Importance of explaining addiction versus explaining negative consequences of drinking, i.e. other negative parental behaviours were seen as primary and alcohol secondary to these and as a child, it was more about explaining the 'bad' behaviour than understanding more about the concept of alcohol dependence
- 'Gut reaction' to alcoholism shaped by childhood experiences
- The gradual realisation that parent was alcohol-dependent took place over many years and required contact with other people who had different drinking styles

NOTES REGARDING EMERGENT THEMES (typed excerpt)

Thinking about alcohol dependence as a concept

This category is made up of ideas relating to what alcohol dependence is as a condition/concept. It seems to be distinct from considerations regarding the development of alcohol dependence as it is more descriptive than explanatory. The cluster includes some of the features or characteristics that would indicate that someone was alcohol-dependent, such as:

- powerlessness/lack of control over drinking, compulsion to drink
- preoccupation with alcohol, gradual reduction of other sources of pleasure/reward
- debates about long-term or short-term nature of condition
- feelings of needing to drink alcohol
- secrecy, hiding, lying (this also includes family's response to alcohol dependence)

Participants also frequently made reference to other behaviours that seem to interface with alcohol dependence, possibly as a way of making decisions as to where it 'starts' and 'finishes'. These related concepts include

- other drinking styles, e.g. social drinking, heavy drinking
- use of substances more generally, e.g. overlaps between alcohol dependence and dependence on illicit drugs or prescribed medication
- the wide range of other 'bad' or negative behaviours displayed by their parents, e.g. being depressed, childish, verbally or physically abusive, which may or may not have been consequences of their drinking

Development of alcohol dependence

This category related to how a person comes to be alcohol-dependent and how a state of dependence might be maintained over time. The category attempts to capture the various causative factors that participants proposed and they seem to broadly cluster into those that initiate or create the conditions in which alcohol dependence may arise and those that only occur after a state of dependence has been achieved.

Pre-disposing causes of dependent alcohol use

- addictive personality
- contextual influences
- physical aspects: drug effects, enjoyment of alcohol
- self-medicating, problem-solving, coping with stress
- intergenerational transmission via DNA/genetics

Factors maintaining dependent alcohol use

- lack of negative consequences
- neurological changes
- role of spouse/significant others

There were also references to <u>how</u> these factors interacted over time and might combine in different ways for different individuals.

Free Nodes

Name	Sources	Reference	Crea
1Conceptualising alcohol dependence_features of alcohol dependence_chronicity	3	4	22/(
1Conceptualising alcohol dependence_features of alcohol dependence_compulsion	4	9	22/(
1Conceptualising alcohol dependence_features of alcohol dependence_preoccupation	4	6	15/(
1Conceptualising alcohol dependence_features of alcohol dependence_subjective experience of reliance	8	27	15/(
1Conceptualising alcohol dependence_related concepts_dependence on other substances	3	6	22/(
1Conceptualising alcohol dependence_related concepts_general drinking behaviour	8	36	15/(
1Conceptualising alcohol dependence_related concepts_other negative parental behaviours	7	14	15/(
2Development of alcohol dependence_initiating factors_addictive personality	10	35	15/(
2Development of alcohol dependence_initiating factors_contextual influences	5	13	22/(
2Development of alcohol dependence_initiating factors_drinking to cope	9	36	15/(
2Development of alcohol dependence_initiating factors_genetic explanations	7	22	22/(
2Development of alcohol dependence_initiating factors_rewarding drug effects	7	11	22/(
2Development of alcohol dependence_maintaining factors_family's responses	4	7	15/(
2Development of alcohol dependence_maintaining factors_lack of negative consequences	3	6	15/(
2Development of alcohol dependence_maintaining factors_neurological changes	3	5	15/(
2Development of alcohol dependence_natural history of alcohol dependence_gradual process	9	41	22/(
2Development of alcohol dependence_natural history of alcohol dependence_individual differences	8	16	22/(
3Attitudes towards responsibility for alcohol dependence_dilemmas_degrees of responsibility	4	11	22/(
3Attitudes towards responsibility for alcohol dependence_dilemmas_difficult childhood as a risk factor	6	9	15/(
3Attitudes towards responsibility for alcohol dependence_dilemmas_understanding versus excusing	7	27	22/(
3Attitudes towards responsibility for alcohol dependence_personal responsibility for control over drinking_choosing to be active in the addiction	8	35	22/(
3Attitudes towards responsibility for alcohol dependence_personal responsibility for control over drinking_fluctuating capacity for control	8	34	22/(
3Attitudes towards responsibility for alcohol dependence_personal responsibility for control over drinking_importance of resources	5	14	22/(
4Affective responses to alcohol dependence_ambivalent emotions towards alcohol-dependent parent_caught between anger and sympathy	9	33	15/(
4Affective responses to alcohol dependence_ambivalent emotions towards alcohol-dependent parent_moderating factors	7	24	28/(
4Affective responses to alcohol dependence_experiences of blame_benefits of blame	4	4	06/(
4Affective responses to alcohol dependence_experiences of blame_parental avoidance of blame	5	8	15/(
4Affective responses to alcohol dependence_experiences of blame_reflections on their own culpability	6	13	22/(

Free Nodes

Name	Sources	Reference	Crea
4Affective responses to alcohol dependence_feelings about their own relationship with alcohol_concerns about risk	7	18	15/(
4Affective responses to alcohol dependence_feelings about their own relationship with alcohol_importance of not being like parent	3	12	22/(
5Active sense-making process	10	125	28/(
6Experience of growing up with alcohol-dependent parents	9	85	15/(