SUBSTANCE MISUSE AND THE FAMILY: The exploration of relationships in the family system within sibling narratives

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ABSTRACT

Substance misuse affects many families, resulting in social, economic, and health difficulties, which has implications for wider society. Due to these difficulties, drug and alcohol services and health services are often accessed, with great cost to the National Health Service (NHS). Despite the growing body of research suggesting family members have an impact on recovery and are negatively affected themselves, treatment continues to focus on abstinence of those with substance misuse issues, with little support available for families. Research also highlights the important contribution our siblings make to our development. However, research into families and substance misuse focuses on the experience of partners and parents, which is also reflected in service provision. As such, siblings are left without a voice or support, and their perspective is not considered.

The stories of six siblings who identified as having a sibling with substance misuse issues were collected, and these interviews were analysed using narrative analysis, underpinned by a constructionist epistemology. The research sought to gain insight into the experience of these siblings, considering how they made sense of the experience, and how it shaped their identity and relationships with others.

Participants struggled to place themselves in their experience, feeling both like an insider and an outsider. Polarisation often emerged in their narratives, with the sibling seeing other family members' actions as bad or good. Siblings often seemed to adopt a 'hero' type role, in an attempt to rescue the family from the difficult situation, in which everyone felt helpless. They struggled to differentiate between whether their 'using sibling' had an illness or if the substance misuse was in their control. The siblings often felt there was a lack of boundaries present, and so tried to create them. Guilt was evident, and at times, seemingly due to feeling they had escaped having substance problems themselves, the participants often felt blame and shame.

The study highlights the distress experienced by siblings, and the need for more support for siblings and their families. It advocates the need for professionals to reconsider treatment options for substance misuse, perhaps including family in the treatment, using more integrated or family-based models. This study argues that the sibling experience should be included in the discussion about substance misuse, and that professionals should seek to understand it further, to help provide adequate support.

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CHAPTER 1. INTRODUCTION

Context is key, particularly in narrative research; therefore, to contextualise the research, I will start with my story and initial motivation for engaging in this work. However, "narrative research offers no automatic starting or finishing points" (Squire, 2008, p. 4). We conceptualise stories as having a beginning and end, helping us bring about order. Yet, as Bruner highlights, narrative is "linear and instantaneous" (1986, p. 153) and the beauty of expressing ourselves in narrative form comes through the ability to have both at the same time, transcending time and space. Therefore, I will start some way into my narrative, providing a snapshot of my experience and insight into what led me here.

I remember attempting to access support when things felt too much at home. Our family dynamics had not changed a great deal, but my perspective had, gradually over the years. I felt worn down and worn out. All would be fine until another incident flared up as my sibling asked for money, or turned up at the house in the early hours of the morning. I attempted different ways of talking to other family members about the situation, but this often resulted in arguments. Everyone felt helpless, disempowered, not knowing what else to do but give in to my sibling's demands and accept the behaviour. I felt frustrated, angry, hopeless. I needed help, but I remember thinking 'Where do I start?'. I trawled through the internet and services I was aware of. I contacted helplines. 'If I was experiencing these issues after many years of working in the field of mental health, how did other siblings feel?' I wondered. The services seemed geared towards the person with the dependency. I eventually tracked down a website: Adfam. I was hesitant to contact them and attend one of the family support groups, as, having been given minimal information, I was unsure of what to expect from this group; however, I thought it would be helpful to get some advice, support, and maybe some perspective. My mother agreed to go too. We arrived to a circle of mainly females: mothers and partners. I wondered where the men were, and the siblings. "We rarely get siblings", they informed me, excited by the prospect of a sibling's perspective. I left the meeting feeling worse than before. The group was situated far from where I lived, and on the journey home I reflected on how much of an outsider I felt in the group. They were very friendly, but there were no sibling experiences available for me to relate to, just lots of parents and partners feeling hopeless and confused. I wondered where I fit in this situation.

Months passed and I felt I needed support again. This time, my sibling had relayed to my mother that they wanted help, so I contacted a local drug and alcohol service, and my mother and father agreed to meet with the carers and support worker. We attended, and were informed about 'tough love' (essentially the process of consistently implementing boundaries and learning to say no), something we had all struggled with in the past. I found it helpful, but we were informed by the carers and support worker that, ultimately, my sibling needed to engage with the service for change to occur. I was dubious that my sibling would engage, and despite showing initial interest, they ultimately backed out. In the meantime, however, we were told that we could access the family and carers group. I was looking forward to attending until I was informed that it ran in the middle of the day, on a weekday. All of my family worked full-time, which meant none of us would be able to attend. Instead, I found a different outlet and supportive space.

I began to use therapy to talk more and more about my experience and the associated difficult family dynamics. During one session, my therapist asked if I had ever considered doing research in the area. We wondered how much the family, in particular the sibling, had been thought about. Further searches made me realise how little research and information existed about substance misuse and families, and specifically, about substance misuse and siblings. Perhaps theory could help. I considered the psychology models I had been taught so far: psychodynamic – based on the mother, father and child triad, and cognitive behavioural therapy – a more individualised model, and began to realise how little siblings featured there also. Where were these forgotten siblings? They need to be thought about too, they need a voice; their stories need to be shared.

Due to this, the objective of my research was to explore the narrative of siblings. The research aimed to hear the narratives of siblings and their experience. To explore how siblings talk about their experience and structure their narrative and consider how impactful the experience is for siblings and the family. Finding out more about the sibling experience within their family system seemed the next logical step in determining what can be done to help.

CHAPTER 2. LITERATURE REVIEW

2.1 Definitions

The term ‘addiction’ is a contentious one (Sussman & Sussman, 2011). It appeared in the Oxford English Dictionary in 1612, initially in relation to alcohol use, and in 1901 ‘drug dependence’ was created. From a medical perspective, the word ‘addiction’ provides a description or underlying explanation for the behaviour; however, it implies “a defect in the individual” (Room, Hellman & Stenius, 2015, p. 34) and failure of self-control. Attitudes are changing, and The Diagnostic and Statistical Manual of the American Psychiatric Association (5th ed.; DSM–5; American Psychiatric Association, 2013a) has now replaced ‘dependence’ with ‘substance use disorder’, moving away from the concept of ‘addiction’ (Room et al., 2015). In popular culture and scientific research, however, the term ‘addiction’ remains widely used (Room et al., 2015). There appears to be inconsistency in the terms used by researchers and practitioners within the field of psychology, and although there has been little research in the area, in the field of counselling psychology, the British Psychological Society’s (BPS) Division of Clinical Psychology has a Faculty of Addictions within it, and often refer in their literature to ‘substance misuse’ to more specifically define drug use. The use of diagnostic categories (particularly in NHS settings) creates tension for counselling psychologists, as the traditional medical model often clashes with the humanistic values of counselling psychology (Larsson, Brooks & Loewenthal, 2012). In this literature review, taking my lead from the papers included, I will use terms such as ‘addiction’ to reflect the terminology used in the research. However, throughout the rest of the thesis, I revert to terms such as ‘substance dependence’ (World Health Organisation, 2015) and ‘substance use/misuse’ (American Psychiatric Association, 2013b) to describe the behaviour of dependently engaging in drug and/or alcohol use (The National Institute for Health and Care Excellence, 2007). This choice is due to the negative connotations of the term ‘addiction’, as described above, and the stigma it may carry.

2.2 Counselling psychology and addiction: a neglected issue?

The UK Division of Clinical Psychology within the BPS dedicated the February 2016 edition of their Clinical Psychology Forum publication to ‘Addictions’; however, the

Counselling Psychology Review[1] has only ever included a few papers about the subject. The papers related to addiction consider developing policy around drug and alcohol use (Hammersley, 2000), using psychometric testing in an NHS addictions service (Ploszajski, 2004), internet addiction gambling (O'Brien, 2011; Shorrock, 2012), and most recently, controlled drug use by gay/bisexual men (Naidoo, 2017). It is worth noting, however, that the field of counselling psychology is much newer than that of clinical psychology, with the Counselling Psychology Review first being published in 1986. In a recent Counselling Psychology Review (Naidoo, 2017), a research paper looked at 'controlled drug use' by gay/bisexual men, and considered difficulties around defining drug use. The paper highlighted the contrast between the BPS guidelines (which work from a subjective and pluralistic model) and medicalised research by Nutt (2009) and Nutt, King and Phillips (2010), questioning drug classifications, thus raising issues around the politics and legalisation of drugs, and therefore stigma and treatment.

Drug use is a broad topic, and this becomes apparent when we look at another paper within the Counselling Psychology Review exploring how we might develop policy around clients' drug and alcohol use within services (Hammersley, 2000). The paper considers the impact of different drugs (both illegal and legal) on clients, how this changes the therapeutic relationship, and the effectiveness of psychotherapeutic interventions when alcohol or drug use (including prescribed medication) is present (Hammersley, 2000). Substance misuse often presents alongside other mental health issues (known as dual diagnosis) and can be interpreted as a symptom or cause of a mental health disorder, as opposed to a standalone diagnosis (O'Brien, 2011). Services can struggle to engage people with dual diagnosis, with the treatment route and guidelines being unclear. Usually, abstinence is encouraged by services, sometimes used as an obstacle for accessing services (their criteria can include clients being abstinent for a certain period of time before being able to access psychological support). However, is abstinence possible or sustainable for everyone? If psychological support is not provided, what happens when previously drug controlled emotions start to rise to the surface? (Crome, Chambers, Frisher, Bloor & Roberts, 2009). Services are able to deny treatment in mental health services due to alcohol and drug use (Hammersley, 2000) by referring clients instead to specialist drug and alcohol services or dual-diagnosis workers, if available, which comes

[1] The Counselling Psychology Review is an equivalent publication to the Clinical Psychology Forum. It consists of a collection of papers that make an important contribution to the field, published by the Division of Counselling Psychology within the BPS.

down to different practitioners' philosophies (Crome et al., 2009). This is subjective and practitioners'/services' views can vary on whether they see substance use as being controllable or as an illness (Hammersley, 2000).

Due to these complexities, it is difficult to know how or where to start in tackling this issue. Counselling psychology aims to consider the subjective experience of the individual (Cooper, 2009), so, perhaps because of this, it has not been deemed necessary to consider substance misuse in more depth, as a separate topic to mental distress in general. However, considering the gaps in service provision, varying practitioners' views on the subject, and general inconsistency in practice when tackling drug use, this could mean people with substance misuse issues miss out on accessing effective treatment (Crome et al., 2009). It seems an important area to think more about.

2.3 Background

It is difficult to obtain consistent statistics on drug misuse, as the definition of 'misuse' varies (DrugWise, 2016). In the latest England and Wales survey, it was found that around one third of adults aged 16 to 59 had taken illicit drugs (excluding alcohol) at some point during their lifetime (Home Office, 2017). Globally, it was estimated that 29.5 million people had a 'problem with drug use' in 2015, impacting not only their lives but those of others around them (United Nations Office on Drugs and Crime, 2017). It is a societal issue, with drug-related crime and violence impacting communities, and drug use negatively affecting families (The British Medical Association, 2015). The total social and economic cost to England and Wales due to substance misuse is an estimated £16 billion a year (The British Medical Association, 2015). Drug treatment is aiding the current situation and is bringing cost benefits. It is estimated that, due to the relief on public costs, there is a saving of £2.50 per £1 spent on treatment (The British Medical Association, 2015). The National Institute for Health and Care Excellence's (NICE) guidelines (2015) recommend psychosocial interventions in the treatment of addiction, including couples behavioural therapy and cognitive behavioural therapy. There is a growing evidence base for treatments including multi-systemic, community-based and family therapy (Copello & Orford, 2002; Copello, Templeton & Velleman, 2006; Copello, Velleman & Templeton, 2005).

Phenomenological research suggests that relationships impact the recovery of 'addicts' (McIntosh & McKaganey, 2001; Palmer & Daniluk, 2007; Watson & Parke, 2011), with supportive friends and family aiding the addict's recovery, and negative family

interactions hindering it (Palmer & Daniluk, 2007). It has been highlighted that family dynamics are inextricably linked with the maintenance of addiction, with siblings even adopting specific roles in this cycle (Huberty & Huberty, 1986). Adverse effects on family members including health issues have also been noted (Mattoo, Nebhinani, Kumar, Basu & Kulhara, 2013; Orford, Velleman, Natera, Templeton, & Copello, 2012; Velleman, Bennett, Miller, Orford & Tod, 1993). DrugScope (2009), previously the UK Centre of Expertise on Drugs, suggest that funding is insufficient in supporting family members impacted by addiction, and highlight that service provisions for family members are patchy across the UK, despite research finding that psychological health improves quickly for family members once they are able to access help and speak about their experience (Salter & Clark, 2004). DrugScope consider that family members subsidise treatment, which would otherwise require funding from the NHS, by providing support or paying for private treatment for addicts, yet not much is known about the family's role (DrugScope, 2009).

Little research has focused on what the experience is like for family members impacted by addiction, in particular the sibling experience. Whiteman, McHale and Soli (2011) suggest that the sibling is often the family member with whom we spend the majority of our lifetime and to whom we are closest. Psychological theories, such as attachment theory, purport that we are relational beings, forming attachments to others, which subsequently influence our personality development (Bowlby, 1969) across our lifespan (and therefore possible onset of psychopathology). This suggests that early life relationships are of importance in our subsequent development. As siblings are both common early and lifelong attachment figures (Whiteman et al., 2011), our experience of them is starting to be considered in a therapy setting (Sanders, 2003), yet little research has considered the sibling experience in the context of addiction.

2.4 Overview of literature review

In this review, I will be focusing on family and sibling relationships where one family member has/had substance misuse issues. I will explore the impact of this and support provided for family members, considering sibling involvement, leading to questions of future progression in this field and suggesting next steps for research. Due to the nature of the literature, with little qualitative research in the field of siblings, the review will be structured using a funnelling approach (Ridley, 2012), starting initially by looking at the family and their role, narrowing down to siblings and their experience. I have included

the most recent and relevant research available in English, to my knowledge, within this topic area.

2.5 The family

2.5.1 The role of the family

Recent European research (surveying 35 European countries) into adolescents and substance misuse suggests that, whilst use of alcohol and cigarettes starts earlier in adolescence (13–14 years old), illicit drug use occurs later (Kraus, Vicente & Leifman, 2016). Trauma, mental health issues, and dysfunctional families were found to be strong determining factors in development of substance misuse issues during adolescence (Herz, Franzin, Huemer, Mairhofer, Philipp & Skala, 2017). Other research has linked parental psychopathology, relational closeness, family conflict (Tobler & Komro, 2010), parenting style (Montgomery, Fisk & Craig, 2008), and parental drug addiction (Gilchrist & Taylor, 2009) to drug use initiation and misuse.

Research consistently illuminates relationships between family functioning and addiction (Rowe, 2012). American family therapists developed family systems theory from a biological theory known as general systems theory, which suggests that to view a system as a whole it must be understood in terms of the relationship between its composite parts (McAlpine, 2013; Minuchin, 1985). Family systems theory views the family as one unifying unit, with each member affecting, and being affected by, other family members (Huberty & Huberty, 1986; Minuchin, 1985). The theory holds that causality is circular. An individual's action is a response to another family member's action and so on, with each person's action evoking further responses and actions, resulting in a circular dynamic within a given context. It considers the individual from a relational perspective, in contrast to a psychoanalytic/Western perspective, which could consider the person as a separate self-organised entity (Sanders, 2014).

From an early family systems perspective, family therapist Wegscheider (1981) observed from her work that the addiction becomes part of the family dynamic, with it creating unhelpful but familiar responses for the family, with unhealthy dependency dynamics present, also maintained by the cycle. Unconsciously, the family system is searching for equilibrium, and due to the familiar nature of the pattern that addiction maintains, in the short term it allows the family to unconsciously feel balanced. This is also known as the family addiction cycle (Stanton, 1997). As a result of this cycle and the investment all

family members have in it, the individual is tied to the family, and therefore, when any one member's response or behaviour changes, the family will unconsciously try to change it back. This is why recovery for the addict is unlikely if treated in isolation from the family, as once they return to the system, other family members will unconsciously try to reinstate their addiction (Rowe, 2012). Stanton (1997) therefore posited that by ignoring the family addiction cycle, treatment will be greatly disadvantaged. Despite unconsciously experiencing this family dynamic as familiar and allowing equilibrium, in reality, this dynamic can be difficult to live in. American psychologist, family therapist, and drugs and alcohol counsellor, Dr. Robert R. Perkinson describes the environment in a home where addiction is present as chaotic and unpredictable, likening it to living in a whirlwind. He comments that everyone's needs are forgotten, as the focus and preoccupation is with the person with substance difficulties. Meanwhile, other family members develop maladaptive strategies in response (Perkinson, 2017).

Family therapy has largely been developed from family systems theory (Todd, 1991), and there is growing evidence that it can be a powerful form of intervention for both adolescent and adult drug use (Rowe, 2012). In the past, there has been criticism of family systems theory within the field of counselling psychology – in one paper it was suggested as circulatory in nature and thus unable to be used in practice (Irving & Williams, 1995); however, counselling psychology now identifies the client as a socially and relationally-embedded being (Cooper, 2009), and acknowledges the importance of working with families and systems (Sinitsky, 2016). Research into family-based treatments of addiction, including functional family therapy, integrative family therapy models, brief strategic family therapy, ecological interventions, multisystemic therapy, and multidimensional family therapy, supports Stanton's notion that treatment may be hindered by lack of family involvement, as family members can act as a motivating force, encouraging the drug abuser to engage in treatment, and stress in family relationships can exacerbate drug use (Rowe, 2012). Research also highlights that family members not only support the person with addiction, but in doing so experience their own distress or even trauma (Dayton, 2010), which can exacerbate the addiction and contribute to relapse of the person with the addiction if not managed properly (Rowe, 2012).

Multidimensional family therapy (MDFT) (Liddle, 2002) is an integrative approach to family therapy, which focuses on development issues for the adolescent experiencing substance misuse issues (targeting relational issues), the parent's functioning and parenting, transactional patterns within the family and external systems (e.g. school),

encouraging more positive interaction between these systems and the adolescent (e.g. working with the family, schools, and the juvenile justice system) (Rowe, 2012). MDFT has consistently proved effective in reducing adolescent substance misuse (Rigter et al., 2013) and improving family function after 12-month follow-ups, across randomised control trials. In a trial with 224 African American male adolescents, MDFT showed quicker and maintained psychological detachment from drugs across the 12-month follow-up, when compared to individual therapy such as cognitive behavioural therapy (CBT) (Liddle, Dakof, Turner, Henderson & Greenbaum, 2008). Another type of family therapy, multisystemic therapy (MST) (Henggeler & Borduin, 1990), is a social ecological approach, targeting the risk factors that produce and sustain the substance misuse by working with the parents to empower them and the community (Rowe, 2012). MST has shown long-term effectiveness across 14 years, significantly reducing the arrests and days incarcerated of 176 American youths, with 54% fewer arrests and 57% fewer days of incarceration compared to individual therapy (Schaeffer & Borduin, 2005). Research suggests family-focused treatments aid family functioning, school performance, healthy adolescent development, and peer relationships, whilst multiple systems approaches such as MDFT and MST also seem to target problem adolescent behaviour (Rowe, 2012).

The evidence base for family therapy is still in its early stages in comparison to therapy such as CBT, but so far outcomes seem positive. Economically, studies have shown types of family therapy such as MST provide the same or better efficacy to alternative treatment and can be significantly cheaper (Stratton, 2016). Economic gain is evident in health services also, as families appear to have an improvement in general family function following family therapy, and thus use health care services less. One study suggested a decrease of 58% in health care use (Crane & Christenson, 2012). Systemic therapy has been shown to be effective in treating substance misuse (reducing use), with a long-lasting effect of up to 23 years post-treatment (Sawyer & Borduin, 2011). However, it is worth noting that often a number of approaches are defined under the umbrella term of family therapy, and in some studies this can be difficult to distinguish. In one study, systemic therapy was defined as any type of therapy using a systemic therapy focus (Sydow, Beher, Schweitzer & Retzlaff, 2010), which included couple, family, group, multifamily group, or individual focused therapeutic intervention; this could arguably cross over with what might be considered in other studies as individual therapy. In line with this, although research has often found systemic approaches to be better than non-systemic approaches,

in tackling issues such as substance misuse, there is less clarity as to whether specific systemic models/interventions have better outcomes than others (Sprenkle, 2012), so more research needs to be done to further investigate.

2.5.2 The impact on the family

It is estimated that addiction impacts around 100 million family members (Orford et al., 2012). Worldwide, family members are reported to experience social and economic stressors, leading to physical and mental ill health in relation to a loved one's substance misuse problem (Copello & Walsh, 2016; Mattoo et al., 2013; Orford et al, 2012; Velleman et al., 1993). It has been suggested that, as a result of these health issues, family members use mental health services, substance misuse services, and hospital emergency services. This poses a significant economic burden, which costs the UK approximately £1.8 billion per year (Adfam, 2012).

Seemingly, little research has been conducted into the possible impact of substance misuse on family members, and the consideration of their needs (Orford et al., 2005). Some researchers are seeking to address this issue. Using two decades of research looking at over 800 family members' experiences of excessive alcohol and drug use, acquired from semi-structured interviews in England, Mexico, Australia, and Italy (Orford et al., 1998; Orford, Copello, Velleman & Templeton, 2010), a team of UK clinical psychologists formulated a Stress-Strain-Coping-Support (SSCS) model. Through their interviews, they found that affected family members were often dealing with the loss of a loving relationship with the person with substance misuse issues. The person struggling with substance misuse would often become aggressive, deceitful, and make false accusations about other family members. There were often financial issues present, with the relative asking for money and drawing in other family members, or using blackmail, creating further difficult dynamics within the family. There was an ever-present uncertainty for family members, not knowing if, or when, the relative with substance issues would stop/had stopped taking drugs, and worrying about their health, safety, and other aspects of their life. Family members themselves experienced poor health, which they attributed to the stress of dealing with the substance-misusing relative, and they would often worry about other family members' health also, due to the stress caused by the situation. Disruption to the family home was reported, as the person with addiction issues often kept different hours to other family members, and participants would worry about the impact of witnessing drug taking or violence/neglect on children within the

home. Participants also reported not wanting to go out due to stigma, shame, or unpredictability of the substance-misusing relative. Participants reported experiencing a plethora of conflicting negative emotions towards the family member with addiction issues, themselves, and other family members, and low self-image/confidence was common, sometimes as a result of self-blame.

The SSCS model was developed to understand the stress and coping strategies used by people impacted by a family member with an addiction, normalising the experience of families instead of pathologising them (Orford et al., 2010). They identified three coping strategies: putting up with it, withdrawing/disengaging from it, and standing up to it. Participants seemed to value being able to talk to others about their experience, as this helped them to cope. They suggested speaking to others in a similar position was helpful or even someone with substance misuse issues, to aid their perspective, and said that having input from professionals who could provide informational materials was beneficial. Participants identified social support as being helpful in different forms. Due to often feeling their responses were criticised by family members, having others positively support their decisions and having a positive regard towards the relative with substance misuse issues was deemed helpful. Help-seeking was sometimes difficult, due to shame felt or secrecy within the family; on occasion, the person with substance misuse issues would not want others to be informed. Although often surrounded with a network, participants largely experienced support as unhelpful. Within the family, members may feel restricted by what others think of them. Friends may offer unhelpful advice of what they would do in that situation. Family members sometimes felt professionals would not allow them to talk through strategies, and felt blamed by them. Based on the SSCS model, a five-step method (Orford, Velleman, Copello, Templeton & Ibanga, 2010) was developed, as a brief psychosocial intervention to be used by professionals, to help support affected family members. A large cluster randomised control trial in primary care and specialist addiction services of the model was carried out, and the creators found a reduction in family members' stress and symptoms of psychological and physical ill health, between the start and end of the intervention (Copello, Templeton, Orford & Velleman, 2010). However, it is worth noting that in the study and research used to construct the model, the majority of family members included were partners or parents of the person with addiction difficulties. The researchers hypothesise that, regardless of the gender or relationship of the family member to the addict, there is a core experience that everyone shares – feeling disempowered due to the undermining control brought about

by the substance misuse, exacerbated by the blame, criticism, and lack of understanding from others, though they also suggest that future research could consider more carefully how or if this intervention could benefit other family members (Copello et al., 2010).

It can be difficult to identify individual family roles and positions in the literature, as the family are often viewed as one body, instead of as individuals, sometimes being lumped together as 'relatives' or 'other' (if not a parent, partner, or child of the addict) in the data, in studies such as Timko et al. (2014) or a paper by Copello et al. (2009). It seems, therefore, that dynamics occurring between family members may be missed, especially relating to specific roles in the family and differences in this experience. Perhaps research needs to explore this further.

2.6 The sibling

Many quantitative and mixed methods studies investigate the likelihood of siblings developing addiction issues if another sibling has them also (Brook, Whiteman, Brook & Gordon, 1991; East & Khoo, 2005; Ersche, Jones, Williams, Turton, Robbins & Bullmore, 2012; McGue & Sharma, 1995), finding that siblings can greatly influence the development of substance misuse issues. The literature seems to look at how using/non-using siblings influence addiction and recovery of their using siblings, but few think about how addiction impacts non-using siblings. This evokes many questions. Why consider the result of addiction on the parent, but not upon the sibling? How important is the role of the sibling? How much do sibling relationships impact us? What is the sibling's experience?

Conger and Kramer (2010) highlight that only recently have we started to recognise the importance of the sibling relationship, both on our development and in promoting health and wellbeing across our lifespan. Attachment theory (Bowlby, 1969) posits that individuals can be impacted by early attachment figures, although it mostly focuses on parents. Research supports this, suggesting siblings can often become objects of attachment, and that this bond resembles or compensates for strains in parental bonds (Whiteman et al., 2011), relieving stress when caregivers are unavailable (Samuels, 1980; Stewart, 1983). This relationship changes across time. Empirical work has suggested a decrease in contact and proximity in early adulthood between siblings (White, 2001), with a stronger relationship again in middle/ later adulthood, as siblings become a source of social support (Cicirelli, 1995) and emotional support (Namyslowska & Siewierska, 2010). Within the field of mental health, sibling experiences in relation to disorders such

as autism, anorexia, and schizophrenia are now being considered, with ideas forming of the possible inclusion of siblings within clinical services in aiding treatment (Schuntermann, 2007); still, when support is provided to families, siblings are often neglected in this provision (McCullough & Simon, 2011).

Drawing on her personal experience and work in addiction treatment and family therapy, Wegscheider (1981) suggests basic 'survival roles' that siblings adopt within the family system when addiction is present. The roles purported include 'hero', 'scapegoat', 'lost child', and 'mascot'. Using case examples, Huberty and Huberty (1986), American social workers and family therapists, consider the implications of these roles in relation to the addict. They highlight birth order and age gaps of siblings as influencing how roles are distributed, and explore how relationship dynamics change with gender differences. They consider the costs and benefits of these roles; for example, a 'hero' (sibling) and 'scapegoat' (addict) dynamic can create polarised identities that siblings may not want to let go, with parents subconsciously reinforcing these ideas. Within this system, Huberty and Huberty (1986) suggest siblings have a strong role in the cycle of addiction, as they become the "sabotaging siblings" (p. 40). They posit that 'the good child/hero' may seek to reinforce the idea that the 'scapegoat' is bad, to make themselves look even more heroic. If an addict is trying to abstain from drug use, the 'hero' may 'sabotage' the recovery of the addict, seeking to reinforce and maintain old roles. They therefore suggest that siblings need help in changing their perception of their sibling "not as a drug abuser but as a person" (p. 40). This early model could hold a lot of stigma for siblings, and could be seen as placing blame on them more than other family members. The term "sabotaging siblings" is highly emotive and is quite reductionist in conveying the complex relationship between siblings. Support for the idea of these roles is limited, but research has shown some evidence of basic survival roles within siblings. Studies looking into parental drinking supported the occurrence of these compensatory roles (Fischer, Pidcock, Munsch & Forthun, 2005; Samuel, Mahmood & Saleem, 2014) using the Children's Role Inventory, a self-report measure to determine this (Potter & Williams, 1991). One study recruited 29 sibling pairs of students from a southwestern US university (Fischer et al., 2005), and found that the greater the parental drinking problem and family dysfunction, the more differences were magnified in sibling roles (Fischer et al., 2005). A later study (Samuel et al., 2014) supported these findings: they recruited 400 adult children of fathers with alcohol dependency from Pakistan. They considered whether the survival roles changed according to gender and culture, but found that they were not

influenced by these factors, suggesting that these roles are universal. However, it is unclear if these roles are limited only to families where addiction is present.

The basic survival roles fit with family systems theory, reinforcing ideas about family dynamics maintaining the addiction cycle; they also highlight long term consequences that may be destructive (Huberty & Huberty, 1986). Huberty and Huberty (1986) suggest that, within the role of the 'lost child', the sibling may be quiet and withdrawn, directing family conflict (surrounding the addiction) and attention away from themselves. Huberty and Huberty (1986) purport that, in the long term, this could cause the 'lost child' to end up being isolated, due to learnt ideas of safety in isolation extending into adulthood, causing problems with relationships or severe depression. Coleman (1978), a family therapist, considered psychological implications for siblings through her observational work with families with alcohol addiction. She suggested that younger siblings did not integrate well into the family and tended to be ignored in family conflicts. She described siblings as often being in "exile" and becoming "a vehicle for anxiety release", and therefore urged siblings to be included in treatment (Coleman, 1978). Other research also denotes potential negative impacts of being a sibling of an addict. Adolescent siblings of substance users have been found to have a higher risk of addiction, homelessness, and depression, in comparison to others their age, and generally to have a higher rate of mental health issues than the general population (Bamberg, Toumbourou & Marks, 2008).

2.6.1 The sibling experience

From the research considered so far, it seems non-using siblings may play certain roles within the family system that maintain the cycle of addiction (Wegscheider, 1981). This has implications for the addict, sibling, and the rest of the family (Huberty & Huberty, 1986). Barnard suggests that siblings see themselves as "more onlookers than directly involved" (2005, p. 44) in the addiction cycle. Conducting her study in Glasgow, anthropologist and researcher Barnard used semi-structured interviews with 23 drug users between the ages of 16 and 26, with longstanding polydrug use problems, 20 parents, 20 younger siblings, and ten practitioners. She was able to consider the impact of drug use on the family's functioning, exploring effects on parents, younger siblings, exposure to sibling drug use on siblings, and practitioners' views on the impact of addiction on the family. Contrary to beliefs of a core family experience (Copello et al., 2010), Barnard's study highlights similarities and differences in roles and experiences between siblings and parents. Similarities between experiences of parents and siblings included worry about

the health and wellbeing of the substance user (especially in their absence), whilst differences included siblings not considering themselves responsible for the user and family in the way that a parent did, leading to feelings of helplessness (Barnard, 2005). Webber's (2003) findings also showed differences in experiences between parents and siblings. The study included interviews and focus groups with parents and siblings in families in Vietnam, where a sibling had substance misuse. Whilst parents and siblings shared feelings of guilt, grief, shame, as well as feeling there was a lack of available support, they had different views on parenting. Often, sibling participants blamed the parents, being critical of parental behaviour towards themselves and their sibling with substance misuse issues (Webber, 2003). Themes that were explored by Barnard in sibling interviews included a wish for a normal relationship with their sibling where they felt they were there for them, a distancing from the substance user, feeling uncared for by the user, and feeling protective of their parents (Barnard, 2005). Barnard found that the few general practitioners (GPs) included in the study voiced that siblings were not a priority concern, and were considered more in terms of what support they could provide for their sibling with substance misuse issues. Contrary to Orford et al.'s paper (2005), research by Barnard (2005) suggests that family members are not necessarily viewed in a negative way by professionals, but are simply overlooked, as the focus is on the person with substance misuse issues.

A paper by Howard et al. (2010) expresses similar themes. In an auto-ethnographic study, seven counselling, clinical, and social psychologists include personal brief narratives of having a sibling with an addiction (Howard et al., 2010). The authors suggest that non-using siblings can form an "addiction to the addict" (Howard et al., 2010, p. 468), meaning that it permeates their lives – due to the huge impact their sibling has on their life, they can never be free of their sibling's addiction. Both Howard et al. (2010) and Barnard's paper (2005) identify that siblings adopt an "unacknowledged role" (Howard et al., 2010, p. 467), finding it difficult to reflect on how they have been personally affected (Barnard, 2005) because the focus is on the addict and other family members, despite the sibling perhaps being the most highly affected family member (Howard et al., 2010). As with Barnard's research, Howard et al.'s (2010) narratives focus mainly on the impact at the onset of the addiction, and how their relationship with their sibling has changed since (with a few narratives mentioning, very briefly, aspects of their early relationship).

Moving forward from Barnard's exploration of family experiences and the narrative contributions of Howard et al. (2010), which highlighted the overlooked position of siblings and suggests they have quite a different experience to other family members, Garney (2002), McAlpine (2013), Incerti, Henderson-Wilson and Dunn (2015), and Tsamparli and Frrokaj (2016) conducted studies focusing purely on the sibling relationship. Tsamparli & Frrokaj (2016) and Garney (2002) analysed the quality of the sibling relationship, by comparing experiences of participants who have a sibling with substance dependency to those in a family with no substance misuse. Meanwhile, McAlpine (2013), Incerti et al. (2015), and Schultz and Alpaslan (2016) solely analyse the experience when a sibling has substance misuse issues.

In the context of US school counselling, Garney's (2002) thesis explored the impact of substance misuse on the closeness of American adult (19–47 years old) sibling relationships, by conducting telephone and face-to-face interviews with participants from sibling pairs with and without a substance issue involved. Substances used included a range of soft (e.g. alcohol) and hard drugs (e.g. crack, heroin). Garney (2002) states her stance at the beginning of her thesis, i.e. that sibling substance misuse has an adverse impact on the sibling relationship and is a negative life event. Using 15–30 minute interviews (mainly via telephone) she compared experiences of ten pairs of siblings (where at least one sibling was abusing substances) and nine pairs of siblings (where substance misuse was not present). Despite the data being qualitative in nature, statistics were created from this information, including findings that 60% of participants felt a closeness to their non-using siblings, compared to 25% whose siblings were engaging in substance misuse. Garney's findings suggested that sibling relationships affected by substance misuse were more distant, had less trust, and there were more issues of communication within the family. Garney (2002) writes that the aim of her research is to gain an understanding of the sibling relationship; however, despite briefly discussing themes from some elements of the qualitative data, such as catalysts for substance misuse and changes in the sibling relationship over the years, the study mainly focuses on percentages of closeness, trust, and family communication reported.

McAlpine's doctoral research (2013), in the context of clinical and forensic psychology, was a grounded theory study of the process and development of sibling relationships in relation to illicit substance misuse among Australian adults. The criterion for adult participants was to have a sibling who currently, or had previously, engaged in illicit drug taking, which they felt had a "significant impact on their life" (p. 62). McAlpine (2013)

recruited ten Western Australians initially, and then a further 15 Australian-wide, aged between 22 and 60. Interviews were 45–180 minutes long, and included a mixture of age and gender dyads (between participants and the siblings that were impacting them), with some step- and half-siblings included in the study. Most siblings reported their substance-using siblings as having severe drug problems. From the study, McAlpine (2013) develops a theory of the adult sibling relationship, when one sibling is significantly impacted by their sibling's substance misuse, to understand coping and consequences and stress and distress experienced by the sibling. However, McAlpine does not state her position within her paper, and with no information about reflexivity, it is difficult to identify assumptions she has that may interfere with this process.

McAlpine's study (2013) analysed many themes, and, in contrast to Garney's research (2002), focused in more depth on the quality of the sibling relationships, through the analysis of qualitative data. However, her work did support Garney's findings about closeness, trust, and communication, finding that siblings with distant relationships prior to the onset of addiction (according to participants' retrospective accounts), continued to be distant when substance misuse commenced, but were still impacted by the addiction due to the way it affected other family members. Whilst McAlpine considers change in the relationship after the onset of addiction, she does not consider the changes to the sibling relationship if the addict has recovered. She suggests further research could be done into the development of sibling bonds in childhood and the impact this has across the lifespan.

Tsamparli and Frrokaj (2016) supported Garney's (2002) findings that communication difficulties seemed present more in the family home within a substance misuse context than a family home without this dynamic. They also supported McAlpine's research (2013) that, over time, closeness in the sibling dynamic changes, with siblings becoming more distant from their substance dependent sibling. Their study provides a more in-depth consideration of themes and further exploration of emotional impact, similar to McAlpine's work. Tsamparli and Frrokaj (2016) used semi-structured interviews, a psychopathology checklist (SCL-90-R) (Derogatis, Lipman & Covi, 1973), family adaptability, cohesion evaluation scales (FACES III) (Olsen, 2000), and family constellation with 40 siblings residing in Athens (Greece), to compare the experience of 20 siblings with a sibling with substance misuse issues, and 20 without. They focused on areas of warmth/closeness, relative status/power, conflict, and rivalry in the interviews, and used interpretive thematic analysis to analyse their data. Participants expressed that

they felt older siblings were no longer sources of guidance or a model for younger siblings. Siblings experienced anger towards the substance-using sibling due to them garnering more attention from parents; subsequently, anger was also felt towards parents. It was evident that participants mourned the 'loss' of the relationship with their sibling. The study highlighted that participants also felt that their sibling's substance misuse impacted their personal lives. Participants experienced anxiety around the impact of drugs on their sibling's health, initially underestimating the problem and being in denial of the situation, being unable to accept that their sibling takes drugs. Participants often blamed parents for ineffective boundary setting, viewing them as weak and spoiling the sibling who is misusing substances, experiencing the family setting as tense, hostile, and aggressive. Participants often viewed the misusing sibling as a 'victim' of their family and social environment, seeing them as the most sensitive and vulnerable family member, and having hopes that their relationship with the sibling could be repaired in the future or revert to how it was. Despite these interesting findings, it is worth noting that Tsamparli and Frrokaj's (2016) participants all came from a shared cultural background (Greek), which the researchers suggested could have had an impact on results, as they described Greek people as having a family structure with strong bonds between immediate family members and extended family. Also, all participants were recruited through their enrolment in a family therapy programme for substance misuse. Both factors could have shaped participants' experience and understanding, creating a more systemic perspective, seeing the family environment as more influential on the situation, with the problem not being viewed as individualistic.

In both Garney's (2002) and Tsamparli and Frrokaj's (2016) studies, it seems difficult to make comparisons between the two groups (families with a substance dependent sibling and those without) across the themes identified. With small sample sizes used and such complex and individual experiences within families among siblings, comparative studies may not provide generalisable information or lead towards accurate conclusions at this early stage of research. However, the studies do start to give an insight into some areas of difficulty for siblings dealing with sibling substance misuse. In contrast, McAlpine's research (2013) is able to consider more closely the experience of siblings within a substance misuse family dynamic.

Incerti et al. (2015) further support these findings, highlighting the lack of attention (within the area of family and substance misuse) given to siblings in the literature, and questions what difficulties might need to be addressed through service provision. They

interviewed 13 female participants (21–56 years old) who had a sibling with problematic substance use (mainly polydrug use) in their grounded theory study, using Skype and face-to-face semi-structured interviews, informed by DeFrain's Family Strength Model. Limitations of this study include having all female participants and using telephone interviews (which fail to pick up on non-verbal communication). Their findings included participants feeling that their sibling's substance use had a negative impact on the sibling relationship and the relationship with their parents. Schultz and Alpaslan's (2016) findings support many of Incerti et al.'s assertions. Their phenomenological study included 28 participants (16 female and 12 male) aged 19–34 years, with 25 male and three female chemical misusing siblings between the ages of 14 and 34 years (Schultz & Alpaslan, 2016). It was conducted in South Africa by social workers, and presented the experiences, challenges, and coping strategies of non-using siblings. It found that the relationships shared between siblings was good before substance misuse began, but that over time, siblings felt a mixture of emotions including feeling betrayed, embarrassed, and experiencing feelings of loss of their sibling relationship (as highlighted by Tsamparli & Frrokaj, 2016), struggling with negative behaviours of their siblings, and sometimes using avoidance as a coping strategy (Schultz & Alpaslan, 2016).

Incerti et al. (2015) suggested that tailored professional support for siblings is necessary, with communication and trust building/rebuilding being highlighted as suggested focus areas, supporting evidence of lack of closeness, trust, and communication difficulties experienced by siblings in other studies (Garney, 2002; McAlpine, 2012; Tsamparli & Frrokaj, 2016). Schultz and Alpaslan's (2016) study echoed this, with participants suggesting that more support was needed for siblings (views also shared in Webber's study (2003)), and that individual or family therapy may be helpful. It seems that, not only are this group overlooked in research studies, but also in service provision and family relationships. This is despite MDFT training and treatment being encouraged in other parts of Europe, the US, and Canada to help tackle adolescent drug use (European Monitoring Centre for Drugs and Drug Addiction, 2017; Liddle & Rigter, 2013).

As mentioned earlier, perhaps the area of substance misuse has been neglected in counselling psychology. This may be due to discordance within the counselling psychology ethos of diagnosing or medicalising clients' issues. Perhaps counselling psychology sees substance misuse as subsumed within the mental health problems of the individual. It does not see it as a distinct problem to be focused on, but as a way of self-regulating distress (McAndrew et al., 2017). Research informs practice (and vice versa)

and Tsamparli and Frrokaj's (2016) study provides more evidence of the important impact of siblings on each other. They suggest counselling psychologists should inform parents of the needs of non-using siblings, to ensure they are not disregarded through their positioning as the 'strong' parental figure within the family. Equally, Tsamparli and Frrokaj (2016) posit that family therapy interventions within the context of substance misuse should not neglect sibling work, as it is fundamental. Incerti et al. (2015) and Schultz and Alpaslan (2016) support this, suggesting service provision needs to be further thought about. However, with limited information on siblings' needs, it is difficult to have insight into the best way to provide support, which this study will consider.

It is clear that, whilst research is limited, some studies are attempting to highlight and fill the gaps in our knowledge of sibling relationships in relation to substance misuse, at times trying to make sense of them by comparing them to a more general experience (Garney, 2002; Tsamparli & Frrokaj, 2016). In attempts to capture the situation, studies reflect that non-using siblings experience interpersonal issues within the family, in relation to anger and shame felt towards parents and/or siblings (Garney, 2002; Incerti et al., 2015; Schultz & Alpaslan, 2016; Tsamparli & Frrokaj, 2016; Webber, 2003), struggling with the change of dynamic in relationships between themselves and their sibling, often feeling a loss of closeness and trust, whilst finding it difficult to communicate with others in the family (Barnard 2005; Incerti et al., 2015; McAlpine, 2013; Schultz &Alpaslan, 2016; Tsamparli & Frrokaj, 2016).

2.7 Rationale for the study

Research seems to focus more on the problem of alcohol (McAlpine, 2013) and its impact on other family members (Barber & Crisp, 1995; Caetano, Nelson & Cunradi, 2001; Holmila, 1988; Mangueira & Lopes, 2016; McLeod, 1993), with less research on illicit substance misuse within the family (Barnard, 2005). Therefore illicit substance misuse will be focused on in this study. It is clear from the research that more needs to be understood about the sibling experience, especially within the context of the family system. Insight into interpersonal patterns could inform treatment (and guide counselling psychologists in their approach) and learning more about sibling narratives could help us understand their perspective further.

Using a narrative method could allow the participant the freedom to tell their story and for their voice to be heard (Smith, 2008). It could also present an opportunity for us to learn more about the structure of their story, which, considering the issues highlighted so

far, would provide an opportunity for siblings that they have not had before. Studies by McAlpine (2013) and Incerti et al. (2015) used a grounded theory approach, which is interested in creating theory from participants' experiences, summarising the data, and eventually identifying core categories, with the researcher taking a more 'expert' role (Barker, Pistrang & Elliott, 2012). Other methodologies, such as narrative analysis, instead place the researcher within the data, acknowledging their influence on it and encouraging reflexivity (Clandinin, Murphy, Huber & Orr, 2009). Narrative analysis acknowledges the individual as being socially and relationally embedded, and the interaction with the researcher becomes a part of this, congruent with counselling psychology epistemology (Cooper, 2009).

2.7.1 Aims

Due to the questions raised and gaps highlighted in the literature above, the aims of the research were:

- To hear the narratives of siblings and their experience, in relation to others, particularly family members.

- To explore how the participants talk about their experience and structure their narrative.

- To consider how impactful the experience is for siblings and family, highlighting possible support needs.

- To examine the family dynamics and relationships and to identify the sibling constructs for themselves within this.

Further to this, research questions were created, based on the aims above. They were intended to further guide the project and hone in on areas of interest.

2.7.2 Research questions

Following on from the aims my main research question is:
Q1. What are the narratives of the participants (including how they structure and convey their story)?

Under which I also hope to explore:

Q2. How do participants narrate their relationship systems?

Q3. How do they create meaning from/make sense of their experience?

By investigating these questions, my research seeks to gain an understanding of what it may be like, as a sibling of someone who is misusing substances. By listening to the stories of the siblings, it is hoped that a better understanding of the lived experience can be gained and of how this is structured in their storytelling. Several hypotheses about certain roles being adopted by siblings emerge from the literature. Some were put forward by family therapists (Wegscheider, 1981), and others by researchers and those with first-hand experience (Barnard, 2005; Howard et al., 2010; Tsamparli & Frrokaj, 2016). It would be interesting to consider within the stories told by siblings if these ideas fit, perhaps gaining a sense of the identity they create for themselves in the family context and how this shapes future relationships with their family and others.

Steffen (2007) argues that an awareness of lifespan development is essential to counselling psychology practice. She suggests that it helps the psychologist to contextualise the client's experience, developing their understanding of the client and aiding the therapeutic process. Alongside this, gaining a better understanding of systems and people's subjective and inter-subjective experience are all important aspects of counselling psychology (HCPC, 2015). By participating in my research, I hope siblings were offered the chance to connect with their experience and voice their story, which research suggests this population in particular find difficult to do (Barnard, 2005; Howard et al., 2010). In contrast to grounded theory analysis, using a narrative analysis could have facilitated this, helping me to consider my own assumptions and reflexivity, allowing the participants' stories to be more visible and my own experience and interaction with the participants to be transparent in the data. I hoped to get a better idea of what siblings would want in terms of support or possible service provision through their stories, and to recruit participants residing in the UK, with a variety of age ranges and gender to add more diversity to the body of research available.

2.8 Conclusion

From the review of this literature, the role of the family in addiction is evident, with some evidence suggesting family therapy can be effective both in helping the person reduce their substance intake and in aiding family function (Rigter et al., 2013; Rowe, 2012; Stratton, 2016). Within the small field of research into the family experience (Barnard,

2005; Orford et al., 2010), the focus seems to be directed towards parents and partners of the person with substance issues, with siblings rarely being considered (Barnard, 2005). With our knowledge of the importance of the sibling relationship in development (Whiteman et al., 2011) and of sibling survival roles (Huberty & Huberty, 1986), it seems that siblings may sometimes be implicated in the addiction cycle (Stanton, 1997). Due to the negative impacts of addiction identified (Bamberg et al., 2008; Coleman, 1978; Huberty & Huberty, 1986), and perhaps due to non-using siblings' paradoxical role of feeling simultaneously involved and not involved (Barnard, 2005; Howard et al., 2010), close and distant, it seems difficult to identify if or what support might be needed by them, although some studies are encouraging more investigation of this (Incerti, et al., 2015; Schultz & Alpaslan, 2016). Despite positive support for parents and partners being identified, it is not yet clear whether the same support will be applicable for siblings (Orford, et al., 2010). It seems that more needs to be understood of the sibling experience before this can occur.

Although research is now starting to explore the experience of the sibling (Barnard, 2005; Garney, 2002; Howard et al., 2010; Incerti et al., 2015; McAlpine, 2013; Schultz and Alpaslan, 2016; Tsamparli & Frrokaj, 2016; Webber, 2003), in the context of siblings using illegal substances, it seems more needs to be considered from a phenomenological perspective, to understand more fully what this experience is like, and to support and add to the current findings. One way of exploring the experience more fully could be to investigate the experience of the sibling relationship across a lifespan, which is what my research sought to do, asking the question 'What is it like to be a sibling of someone with substance misuse issues?'. Research has suggested that, in the long term, psychological difficulties are likely for non-using siblings (Bamberg et al., 2008; Huberty & Huberty, 1985); therefore, as counselling psychologists, it is likely that we will come into contact with this client group. My research could help both ourselves and our clients to make sense of their experience. I hope it will add to the perspectives of other experienced realities of siblings to the limited existing body of literature. My research may also suggest, from a sibling perspective, that there is a need for more support for siblings or other family members and what that might be. It could illuminate other related issues mentioned at the beginning of the review, such as how the recovery of the person with substance difficulties is affected by the family, and the understanding of family relationships and roles, from a different perspective.

CHAPTER 3. METHODOLOGY

This section starts by providing a rationale of my epistemological stance within the context of my work as a researcher, practitioner, and individual, and how my method choice fits within this. Later, the method is explored in more depth and is critiqued, along with the areas of ethics and research quality, considering challenges encountered. Finally, the data collection process is explained and a summary of participants is presented, laying out the analysis process I engaged in.

3.1 Counselling psychology tensions: The scientist-practitioner vs. reflexive practitioner

Counselling psychology grapples with difficulties in applicability of scientific theories to unique human beings (Schön, 1987), negotiating the conflict between technical and relational. In my clinical practice, I negotiate the tensions between technical and relational every day; for example, using cognitive behavioural therapy with substance misuse clients in a relational way, within a positivist context (the NHS) (Leahy, 2008), which is predominantly concerned with diagnosis and quantifiable results. The initial thought of conducting a piece of research made me question whether the role of researcher would trap me in a technical position, with my initial assumptions leaning towards quantitative and 'scientific' stereotypes; however, upon further reading, I realised that research could be relational, provided that the appropriate methodology was adopted.

The scientist-practitioner model attempts to manage the sometimes stark contrast between research and practice by 'marrying' the two, with circular learning encouraged from one aspect to the other (Hays-Thomas, 2006). This reflects a similar cycle to the data analysis process, which will be discussed later.

Within the counselling psychology field, importance is placed on being a reflexive practitioner, which steers away from "a positivist epistemology of practice" (Martin, 2010, p. 553). Part of this includes counselling psychologists and clients co-creating meaning (Martin, 2010). This is done through valuing the subjectivity and intersubjectivity (Cooper, 2009) that informs the therapeutic interaction, if we take the definition of subjectivity to include the process of our experience of affect, desire, and imagination being "organised, channelled and transformed" (p.20) to create our sense of

self (Blackman, Cromby, Hook, Papadopoulos & Walkerdine, 2008). It is through this sense-making that both participate in the interaction. Caught between the roles of empirical-scientist and subjective-reflective-practitioner, counselling psychologists manage "two different underpinning philosophies" (Kasket & Gil-Rodriguez, 2011, p. 21).

3.2 Qualitative vs. quantitative methods in counselling psychology

Ponterotto (2005) suggests that qualitative methods and the embracement of postmodern perspectives are essential for the progression of counselling psychology, which serves the purpose of supporting the exploration of complex human phenomena, and bridges the gap between research and clinical practice (Thorpe, 2013). However, the literature and training has taught me that research works in a circular dimension, with quantitative research highlighting gaps for qualitative study and vice versa. As practitioners, we draw on different theories applicable to the subjectivity of the client, so too in research we must use methods and paradigms most relevant to the unique research question posed (Kasket, 2012). Therefore, Kasket (2012) reminds us that being a counselling psychologist researcher is not synonymous with being a qualitative researcher. Whilst quantitative research focuses on prediction, qualitative researchers seek to understand experiences through an experiential process (Clandinin & Murphy, 2007). Due to the nature of my research question, seeking to gain detailed insight into individuals' subjective experiences, it seems most appropriate to adopt a qualitative method.

3.3 Ontology as a practitioner and researcher

Counselling psychology researchers are open to the choice of many research paradigms, valid for guiding inquiry into their research question and research project (Kasket, 2012). Paradigms have been mapped along a continuum differently by various authors. However, there is a general consensus regarding the extreme points of these: the positivist/scientific paradigm at one end and social constructivism/critical paradigm at the other (Scotland, 2012). Positivist and post-positivist paradigms are based on a realist ontology (Ponterotto, 2005), which sees the world as predictable and based on cause and effect relationships (Willig, 2013). As a practitioner, I am presented with clients' different subjective experiences, which makes it difficult for me to see the world from a realist or critical realist perspective. Critical realism sees an objective reality, but believes part of it can never be known, emphasising that our cognition/perception is always limited/filtered due to the social structures that exist, which can only ever be inferred

(Meteyard & O'Hara, 2015). Postmodern paradigms such as constructivism-interpretivism and critical-ideological paradigms hold a relativist ontology, believing in multiple realities (Ponterotto, 2005), lending themselves more to the reflexive practitioner model.

3.4 My epistemological stance

As a researcher, I see myself as a socio-constructionist. Within the constructivism-interpretivism paradigm, I am interested in the lived experiences of siblings, although I acknowledge that the wider social context is important in influencing us and structuring our world – an element which perhaps the critical-ideological paradigm investigates more deeply. The constructivism-interpretivism paradigm helps to bring out and deeply reflect on constructions in the siblings' accounts, in order to find meaning and deeper insight, through a hermeneutic process. Though not seeking to actively change society as the critical-ideological paradigm attempts to do, the constructivism-interpretivism paradigm will give a better understanding of the experienced realities on a micro level, perhaps leading to further research or practices that will create positive change for this group of people and their families.

Being a scientist-practitioner, my professional experience of siblings has led me to conduct this research, as has my personal experience. As a reflexive practitioner, I am aware that my lived experiences influence my work with clients and will do so in my research. The constructivism-interpretivism paradigm highlights both this and the importance of reflecting on how the researcher's experience influences the process of the co-constructed reality within the research process with participants. This paradigm is consistent with some of the key values of counselling psychology: appreciating subjectivity and intersubjectivity, reflexivity, empowerment (Kasket, 2013), and valuing difference and diversity (Rafalin, 2010), and also fits with my own values, both personally and as a practitioner and researcher.

3.5 Method choice in the context of my role as a practitioner

Narrative research in particular considers the relationships and dynamics between individuals and our existence as not being separate from others, but interrelating (Clandinin et al., 2009). It also seeks to give voice to those who are often neglected within the usual public discourse (Squire, 2008); these are also key aspects of the counselling psychology ethos (Cooper, 2009). Narrative approach assumes that individuals construct

and understand themselves through language (Crossley, 2000a). Fitting with my experiences as a practitioner, many agree that the process of therapy is narrative (Epston & White, 1999) – clients (like all of us) tell themselves and us their experiences through stories. We can help clients heal by listening to their stories; helping them to re-author stories or construct alternative ones.

Psychodynamic and humanistic approaches cross over with narrative psychology, which also "focus on individual 'depth', uniqueness and meaning" (Crossley, 2000a, p. 8). Freud, Adler, and Jung recognised narrative and life stories as important in therapy, and Spence argued that, in a psychodynamic context, "personal truth relies upon the construction of a narrative truth" (Willig & Stainton Rogers, 2007, p. 3). I agree with the suggestion, developed by Schafer, that narrative is the vessel for truth and reality (Willig & Stainton Rogers, 2007), *with a caveat*: I think narrative can provide access to multiple truths and realities for individuals/participants and therapists/researchers in the moment that they are constructed/reconstructed, based on a relativist ontology. There is not one objective truth; these truths are only some of many available to us at any given time.

In line with the constructivism-interpretivism paradigm, stories are subjective and unique: "several narratives can organize the same facts into stories and thereby give the facts different significance and meaning" (Polkinghorne, 1988, p. 181). Epistemological underpinnings of narrative methods vary, but generally move between that of gaining an understanding of the individual and social change (Squire, 2008). I seek to use narrative in a way that allows the individual to remain in focus, whilst not decontextualising and therefore misunderstanding their experience.

3.5.1 Other methods

Some criticisms of discourse analysis and postmodern methods are that they tend to 'lose' the individual or subjective experience by becoming too engulfed in language and discursive nature (Crossley, 2000a). They consider social construction and wider social implications, fitting more with the critical-ideological paradigm (Willig, 2013) and becoming too abstract (Crossley, 2000a), whereas methods such as interpretative phenomenological analysis (IPA) focus less on the story and its construction. IPA is interested in the subjective experience of the participant; however, it does not allow the participants the freedom to tell their story in narrative form. The researcher has more control over the structure of the interview, which restricts the participant in the structure and reconstruction of their story. Mostly, IPA is adopted from a critical realist

epistemological stance, assuming that there are certain facts about the human experience that can be ascertained through consciousness, by applying the correct methods (Crossley, 2000a).

While IPA and discourse analysis are valid methods for other research purposes, considering my research question and paradigm perspective, narrative seems to be the methodology that fits best with these. Narrative finds a balance between IPA and discourse analysis. It is grounded in specific individual experiences, whilst also being interested in the culture, context, and wider discourse in which this experience is situated (Clandinin & Murphy, 2007). In narrative analysis, the researcher's starting point in analysing the narrative is the narrator. This can differ in thematic analysis, for example, where researchers are sometimes unable to retain contradiction and continuity in the process (which can be detrimental in the wider narrative), due to the way themes can be created (Braun & Clarke, 2006), sometimes resulting in decontextualisation of the narrative (Baú, 2016). In narratives, we often try to create a stable idea of ourselves, based on which we can compare and make sense of ourselves and experiences, considering subjectivity, whilst not forgetting the social context and construction of the experience between researcher and participant (Crossley, 2000b). However, in practical terms, "text and context within a narrative are like reversible figure and ground: both create the whole, yet at any given moment we can only focus on one" (Zilber, Tuval-Mashiach & Lieblich, 2008, p. 1048), which will be a tension to be grappled with throughout the analysis.

3.5.2 Narrative method

In personal therapy there have been many times that, by telling my story, I have attempted to make sense of the experience of being a sibling of someone with substance misuse issues. When this has occurred, I have felt that my narrative has allowed me to make meaning from my experience, not just describe it. This supports Labov's (1997, 2001, 2002, cited in Squire, 2008) argument, that narrative is an explanation, not just a description. When working with clients, I have noticed a similar phenomenon, and some clients have commented on how simply sharing their story has helped them to make sense of their experiences. This also fits with the aspects of narrative noted by Squire (2008), who suggests narratives are "sequential and meaningful", "definitively human", "'re-present' experience", and "display transformation or change" (p.17). This reflects the core values of counselling psychology, which advocates a person-centred, humanistic, and empowering approach (Cooper, 2009; Kasket 2012). Through re-presenting stories by

telling them, a process occurs that allows transformation to happen, changing the words to meaningful experiences as they are made to fit in some sequence within the person's life.

For the purposes of my research, narrative appears to be a good approach. The investigation of the participants' experience through narrative will allow them to make meaning from their experiences as siblings in the context of substance misuse, which, as the research currently suggests, can be a place of chaos, distancing, and feeling inside yet outside of the experience (Barnard, 2005). Experience-centred narrative research proposes that, through narratives, experience can become a part of consciousness, which perhaps has been difficult for these participants to do before if they have been unable to place themselves within the experience. In addition to this, narrative uses a hermeneutic approach to seek understanding and interpretation, instead of trying to bracket our experiences as a researcher (as in some forms of IPA). The researcher is seen as having an active role and influencing the results of the data (Clandinin et al., 2009), hence reflexivity is essential. Reflexivity is an important aspect of being a counselling psychologist researcher, as it helps to inform the reader how the work evolved and was shaped by you, providing a rationale for decisions made at each stage of the process (Kasket, 2012). The narrative method acknowledges that, as with the process of therapy, this is an interactive process. It seems important to use a method which considers this, particularly as an insider researcher, which brings with it strong assumptions and emotions, fuelled by my own experience, that interact with and guide the project.

3.6 Ethics

Ethical approval was gained from the University of East London School of Psychology Research Ethics Committee (Appendix 2). The process of applying for ethical approval provoked ethical questions that needed to be considered and managed. However, despite this planning, further ethical questions arose during the interview process; I will briefly discuss some of these.

Narrative research seeks to give participants power. One of its assumptions is that the researcher will help the participant to bring meaning to, and organise their experiences through stories (Willig, 2012), with the participant, not the researcher, creating meaning through their narrative (Baú, 2016). However, the interviews were conducted for research purposes and, as such, I questioned whether the power ultimately lay with the researcher (with the participants prompted in the interview by *my* agenda as a researcher). Through

discussion with my research supervisor and research consultation group, I reflected that this might not be the case, as participants may have their own open and/or hidden agendas too. This was highlighted in some interviews, through a prompt, where I asked participants why they participated in the study. During one interview, the participant spoke about wanting people to hear a different story to the "stereotypical one" they felt society had, which included people using substances being uneducated and involved with crime; however, the participant also seemed to be questioning or wanting answers as to what they should do in their situation, perhaps wanting to use the interview as a counselling space. They spoke about having considered counselling before, and commented that they found the interview process helpful to talk through their feelings. Another participant said that they wanted to share their recovery story to give others hope; however, at the end of the interview, they also shared that they had their own upcoming dissertation and so it could have been that they were seeking to learn more about the interview process by participating. Although I tried to approach the interviews in an empowering way, led by the participant (as suggested by Riessman, 2008), it was difficult. I felt, at points, that the participant looked to me to direct the interview with further questions (which reflected times, as a practitioner, of being seen as the 'expert,' despite wanting to be the 'facilitator' of the process, striving for a non-hierarchical relationship (Cooper, 2009)), which took away from them sharing their story. As a novice researcher, this was a new role for me, and it felt that during the interviews the power dynamics were constantly in flux and had to be negotiated throughout.

Ethically, I screened the participants and provided information of support services (Appendix 5), to ensure they were not at risk; however, I wondered if they would be left feeling emotionally vulnerable following the interview (they all verbally claimed to be okay directly after the interview). Despite the interviews not being a direct therapy, many participants at the end of the interview commented that they found it a helpful and therapeutic process, supporting similar assertions of the benefits of the process by Holloway and Jefferson (Elliot, 2005) and Baú (2016) that, in a community setting, narrative approaches can create change for the individual. Considering the BPS's guidance (2009), it was important to remember that the participants and society stood to gain much from the data obtained through this process, and that the brief emotional difficulty possibly encountered by participants was minimal in comparison to the potential benefits.

Due to my lens when looking at the interviews, it is likely that I have interpreted their stories in a different way to the intended meaning of the participants (Josselson, 2007). It would be difficult to honour their words and story exactly as they intended it, and from a socio-constructionist perspective, I believe this would not be possible. I sought to replicate what I feel was experienced and meant by the participant in those moments, not seeking to deceive or misrepresent them (BPS, 2009).

3.7 Research quality

There is much debate over how to measure validity and reliability in qualitative research (Leung, 2015). Riessman (2008) argues that if the method development and sources are accurately described, and fit with epistemology underpinnings and the research question, then the research will be valid. The most important issue should be that the research empowers the participants and informs further research and change. Leung (2015) supports this, that "choice of methodology must enable detection of findings/phenomena in the appropriate context for it to be valid, with due regard to culturally and contextually variable," (p. 325) (which narrative analysis does), and suggests that reliability can be achieved through constantly verifying the accuracy of the text by ensuring that information is not taken out of context and is represented in a way that best fits the intention of meaning originally conveyed by the participant in the interview. This can be done by consistent comparison to the original data or through triangulation (with peers) during the analysis process.

Smith and Sparkes (2006) highlight the difficulty in addressing validity and intersubjective reliability of data when interpretations are subjective. I am aware that my own motives and experience will influence the results of the data, influencing my analysis and interpretation of the research question, and what has influenced me (internally and externally) to ask various questions during the interviews and throughout this project. Narrative analysis acknowledges that it can only give us an opening into an aspect of an experience and not allow us to understand it in its totality (Willig, 2013). I acknowledge that some of the participants' experiences will be accessible through consciousness, and other parts will not. Therefore, as a researcher, I believe it will be important to reflect on this during analysis, acknowledging that psychodynamic theory, which informs my training as a practitioner, will influence my thinking in perhaps trying to understand the experience more fully. With that in mind, and my own closeness to the experience, it will make it more difficult to find a balance between empowering the participant, by allowing

their story to be heard, and not "interpreting beyond the data" (Willig, 2013, p. 44). One way I sought to manage this was by asking peers to analyse sections of the transcript, opening up possible interpretations and being able to compare and contrast to see if my observations matched, or were similar to theirs (triangulation).

However, in line with Ricœur's ideas (1991), interpretation and transformation of meaning occurs even in the initial stages of transcribing (when we change speech to text), and continues throughout the process. Participants were sent copies of their transcripts to verify that the transcripts were accurate representations of the interviews, this helped to limit misinterpretation in the initial stages. Ricœur suggests that we interpret the text through ourselves and therefore gain a better understanding of ourselves through the process, so it could be argued that the data says more about me and my story than the participants and theirs; although, considering the hermeneutic circle of explanation and interpretation, the reader of my thesis will also add further meaning to the text (if reflected upon), learning more about themselves in the process. Does the continual interpretation render all information invalid? Some suggest that because of this, concepts such as validity and reliability cannot be applied to narrative methods (Wiklund-Gustin, 2010). One critique could be that I am not able to replicate the participants' exact meaning; however, it is not a purposeful deception, but a natural occurrence (Josselson, 2007), and from a socio-constructionist perspective I see the participants' meaning as contextually bound, so cannot be exact. Similarly, with the process of narrative, I believe certain aspects of the text will connect more or less to the reader (due to their own context), activating different ways of understanding different aspects of possible sibling experiences. This will add another layer, not take away from the meaning of these experiences.

3. 8 Data collection

3.8.1 Recruitment

The most relevant research related to siblings has been conducted in countries outside of the UK (Greece, Australia, Vietnam, South Africa, and the USA), which could have cultural implications (Tsamparli & Frrokaj 2016). It would be useful to consider the experiences of UK residents, and if experiences vary across cultures, which research suggests may be the case (Orford, Velleman, Copello, Templeton & Ibanga, 2010). The age and gender of participants seem to also have been restricted in previous studies; for example, Barnard's study only considers younger sibling experiences, and Incerti et al.

(2015) use only female participants. Therefore, I hoped to recruit a UK sample with a mixture of ages and genders.

Participants were recruited via Change Grow Live (CGL) – a national substance misuse service, online support forums, Facebook groups, advertisements (e.g. in supermarkets, police stations), and word of mouth.

The initial criteria for recruitment required the following from participants: (1) to be over the age of 18; (2) to have a sibling with substance issues (currently/having previously misused illegal substances); (3) to have lived/currently live with this sibling; (4) the sibling misusing substances will have received/be currently receiving formal support (from CGL, NHS, etc.); (5) participants will not be currently misusing substances themselves (within the past 6 months).

Criterion (4) was used to discern the severity of use. However, two participants were included who had siblings who were misusing substances but had not received formal support, as it was clear from behavioural changes and the impact on them and their families' lives that their sibling's misuse of substances was severe and ongoing. Criterion (5) was to ensure ethically that participants were not in a vulnerable position to be especially affected by the topic, and were able to psychologically participate in the study, without excluding people who may have had difficulties with substances themselves in this past.

The aim was to recruit 8–10 adult participants. Despite no prescriptive rules for narrative analysis, for phenomenological research methods such as IPA, it has been recommended to include between four and ten participants for professional doctorates (Hefferon & Gil-Rodriguez, 2011), so I attempted to reach the higher end of the scale to ensure I had enough information. Due to time constraints, resources, and perhaps due to stigma (Drug Policy Alliance, 2014), it proved difficult to recruit eight participants, even with CGL advertising the study in some of their services and liaising with staff, service users, families, and carers to inform them of the study. I was contacted by seven participants; however, only six were suitable. Within the literature, there appears to be less focus on exact sample size numbers; instead, it suggests researchers aim for a rich, in-depth analysis (Hefferon & Gil-Rodriguez, 2011; O'Reilly & Parker, 2013), rather than a narrow and shallow analysis, which can occur as a result of including too many participants (Hefferon & Gil-Rodriguez, 2011). Due to this, some suggest a sample size

cannot be determined until after data collection commences, when the researcher is better able to make this judgement (Tai & Ajjawi, 2016) and consider practical and contextual factors pertaining to their individual study (Hefferon & Gil-Rodriguez, 2011). Once I had completed six interviews, it was clear that the interviews were dense and rich, and in order to convey the interviews in enough depth within my analysis, six participants would be enough, perhaps even too many to convey their stories in as much depth as I had initially planned.

Prior to interviewing the participants, a colleague used the interview schedule to interview me in a thirty-minute interview, so that I could consider my own responses to the prompts and assumptions that came from my own experience. I transcribed this interview, to be used in the analysis stage (listened to and read), helping me to be more reflexive.

3.8.2 Procedure

The participants were contacted and invited to take part in an interview. During this process they were provided with an interview schedule to allow transparency of my agenda (areas I was interested in). The interview schedule provided an example of possible questions that they could be asked and possible prompts (Appendix 1.3), in the hope also of allaying any anxiety they may have about the process. However, they were reminded that I was interested in their story and the interview would be led by them.

The interviews occurred at different locations, according to wherever was convenient for the participants. This included CGL premises, a private room in the University of East London, Stratford, and participants' places of work. It was ensured that the setting was safe and confidential for both the participants and myself. I was the interviewer and I used an audio recorder to capture the interviews and transcribe them later. The interview started with a demographic questionnaire (Appendix 4), and then the participant was invited to share their story in a semi-structured interview, as this type of interview encourages a narrative response (Hiles & Cermak, 2008). I used the interview schedule as a guide to help prompt the participant, or to clarify information.

3.8.3 Participants and demographics table

A total of six participants (five women and one man) were interviewed, with the interviews lasting between 45 and 100 minutes. Following the interviews, I made note of my observations and reflections, to add to the audio data. After transcribing the interviews

verbatim, along with the demographic information provided by the participants, the transcripts were used to compile the demographics table and core narratives (included later in the analysis). Please see the demographics table below for demographic information. Certain details have been changed to maintain participant anonymity.

Demographics table:

Participant (ppt) no.	1	2	3	4	5	6
Age	31	41	51	44	25	39
Gender	Female	Female	Female	Male	Female	Female
Ethnicity	White British	White British	White British	Black Caribbean	White British	Black British
Ppt's relationship to sibling with substance misuse	Sister	Sister	Sister	Brother	Sister	Sister
Current age of sibling	33	40	50	40	30	50
Age of ppt when sibling started to misuse substances	16/17	21	21 (answers related to one specific sibling)	29	12	24
Age of sibling at start of misuse	18	20	20	25	17	35
Length of time living with sibling	1 year and then brief periods in between (whilst sibling was using- post childhood)	20 years (whilst living at home)	18 years on and off (post childhood)	3 years (whilst sibling was misusing drugs- post childhood)	20 years (including childhood)	3 years (whilst sibling was

						misusing substances)
Substance/s taken by sibling	Steroids, cocaine and crystal meth (last few years)	Cocaine, heroin and cannabis	Crack cocaine	Cannabis and alcohol misuse	Cannabis	Cocaine
Current misuse of sibling	currently using	methadone and alcohol abuse	none	none	none	unsure
Support/services accessed	28 days at well known mental health hospital (10 yrs ago) and recently had counselling in Europe	CGL (formerly CRI)	CGL (formerly CRI)	Army and church support	Young carers support	Probation service
Other siblings in family	0	0	4 (2 sisters and 2 brothers (combined biological and adoptive))	1	0	2
Family set up	Mother, father, older brother and ppt	Mother, father, younger brother and ppt	Adoptive family: 2 sisters, mother, father and ppt	Grandmother, 2 younger brothers and ppt	Mother,father, older brother and ppt	Mother, father, 3 older sisters and ppt

3.9 Analysis process

Despite being a dominant frame for social science research, narrative analysis does not follow a structured analytic process (Hiles & Cermak, 2008; Squire, 2008), with no "best way" to conduct it (Sparkes, 2005). Many approaches can be taken. The primary requirement is that the analysis is systematic and clear, and that it considers the structure, function and psychological/ social implications of the narrative (Willig, 2013).

Narrative analysts agree that the analysis process begins at the interview stage. Creating an interview schedule and interviewing participants are both important elements of the process that require a great deal of thought, practice and skill (Reissman, 2008). The narrative interview can help the participant reconstruct their story, enable them to guide the research through the structure of their narrative, and also facilitates participant empowerment (Larsson et al., 2013).

3.9.1 Interview schedule

The interview schedule was developed in accordance with the previous literature, the research questions and aims of the study. It consisted of a few open questions, inviting the participants to narrate their own story. Prompts were used (if necessary) to explore, more deeply, family dynamics and relational aspects of their experience. The literature focuses on different points of the sibling experience. Studies by Howard et al. (2010) and Barnard (2005) focus on impact from the onset of siblings' substance misuse. Other studies consider change in the sibling relationship, noting dynamics in the relationship prior to onset (Garney, 2002; Schultz & Alpaslan, 2016; Tsamparli & Frrokaj 2016). None considered the impact when siblings recover from their substance misuse. This posed questions for the future around how/if changes to sibling/family dynamics occur when recovery happens, and the impact on siblings across their lifespan (McAlpine, 2012). I wanted to ensure that these elements of the narratives were explored. As a result, in the interview schedule I encouraged participants to consider the past. For example, "Do you remember when your sibling started using substances?", focus on the present " How are things now?" and consider the future and change " How do you envision the future?", "has anything changed?," to gain a fuller picture of their experience over time. The interview schedule shaped the data, in that it encouraged participants to think about their past, the impact of their sibling's substance misuse, and what could have been different, contextualising the experience and making them think about change (Barone, 1999).

Due to the sensitive nature of the topic, an interview pilot was conducted on myself by a colleague, to evaluate the interview schedule. This enabled me to gauge how the participants might feel (based on my own experience) in relation to being asked such questions, and ensure that the tone and way the questions were asked did not feel too intrusive or difficult. This process also allowed me to identify some of my assumptions, through my responses. I found it difficult to recall certain details about the experience and felt quite open and exposed by the end of the interview. This informed adjustments to the schedule. Initially, the interview schedule did not include the questions "what advice would you give others in your situation?" and "how did you feel talking about it today?" These questions were added to the end of the schedule, following the pilot. After debriefing with my colleague, we felt that ending with these questions would leave the participant feeling more contained. Also, more prompts were added to help the participant hone in on details around the start of their sibling's substance misuse.

3.9.2 Analysing narratives and writing up

Crossley (2000a) states that the aim of a narrative analysis is to "produce in-depth analyses and insight into individual case-histories which appreciate the complexities and ambiguities of [these] interrelationships" (p.104). This was achieved through the following process.

I transcribed the interviews verbatim and checked they were accurate, listening to interviews repeatedly to immerse myself in the data and get a stronger sense of the narratives, noting any emerging themes or personal reactions (Crossley, 2000a; Reissman, 2008). I read through the transcripts, making notes and observations. In between reading the scripts, I would return to listening to the interviews so as not to miss any tonal changes or non-verbal cues evident on the tape.

The aim was to ensure an in-depth analysis (more than just the content of the narratives) was conducted, in accordance with Crossley's approach (2000a). However, as Reissman (2008) highlights, the very nature of "narrative encompasses long sections of talk-extended accounts of lives in context that develop over the course of single or multiple research interview or therapeutic conversations" (p.7). Therefore there was a lot of data to analyse. Following Langdridge (2007) and Hiles and Cermák (2008)'s guidelines for narrative analysis, I worked through the narratives repeatedly, asking different questions of the narrative. Narrative tools helped me to do this; they enabled me to begin to make sense of the structure and complexities of the data (Reissman, 2008). Identifying the

narrative tone, story type and core story created a starting point. McAdams posited (supported by developmental psychology research) that the narrative tone is influenced by the experience of secure or insecure attachments in formative relationships (McAdams, 1993). It therefore seemed pertinent to consider the narrative tone (optimistic or pessimistic) in this study, as it could add a further layer of insight into relational dynamics. An optimistic tone reflects the participant being hopeful of future improvement in their circumstances, or can be evident due to positive experiences within their narrative. Meanwhile the opposite is true of a story with a pessimistic tone. Alongside this, the type of story (hero, tragedy, detective story) (Sparkes, 2005) was considered, helping to identify if Wegscheider's survival roles (1981) existed within the narrative. A summary of the participant's story was made (Appendix 7), known as a 'core story' (Mishler, 1986). A core story is often used in the narrative analysis process to help reduce the interview data (Polkinghorne, 1988; Mischler 1986; Labov, 1997). Though, as Crossley (2000a) states, "whereas other qualitative research methods such as interpretative phenomenological analysis (IPA) and discourse analysis tend to break the text down into themes, a narrative researcher will try not to fragment the text, but will instead view the narrative as a whole" (p. 147). It was difficult to find the balance between reducing the stories enough so that they were manageable to conceive, without losing the narrative. I kept this in mind throughout the process moving back and forth between elements highlighted by the narrative tools, but always returning to the recorded interview and scripts so as not to lose "the narrative as a whole".

Narrative tools helped to form structure, a broad sense of the tone and identity roles within such a rich amount of data. However, it still proved difficult to know where to begin to create focus points within the data, particularly because I was approaching the data in an exploratory way, in the 'context of discovery,' looking to examine the data without "ready-made answers" (McAdams, 2012, p. 17). My research questions acted as a guide and at this point in the process McAdams' (1993) protocol was implemented to provide a useable framework.

When researching methods, I found Labov's method (1972) allowed a narrowing of large amounts of text, but importance was placed on the event rather than the experience of the participant (Andrews, Squire & Tamboukou, 2013). Other approaches required complex coding systems unsuitable for a first-time researcher, or used analysis methods focused on linguistics (Gee, 1991); however, McAdams (1993) devised a helpful approach to analyse autobiographical stories (Crossley, 2000b). McAdams (1993) did this by devising

an interview protocol that allows the researcher to lead the participant through their life story, considering life chapters, key events, significant people, future script, stresses and problems, personal ideology, and life theme, to draw out and explore whole personal narratives in relation to identity and the self. This protocol has been used by many studies when exploring personal narratives (Gallia & Pines, 2009; Hardtke & Angus, 2004; McAdams, 2012; Yair & Soyer, 2008). Due to my research not being concerned with the whole life story, I felt that this protocol was not applicable during the interview phase, but could be more useful in guiding analysis of the data instead.

Due to my research questions being specific in their focus, concerned with the interaction between the self, relationships and the experience (embedded in the relationship between the narrative, identity, and self), I tailored the areas highlighted in McAdams' (1993) interview protocol towards the focal points of my research. I was interested in the interpersonal relationships (family, support network, and romantic relationships), the moment that the participant realised their sibling had substance misuse issues, emotions, key events before and after the misuse, future outlook, support wanted or obtained, and personal ideology (beliefs about substance misuse and how the experience shaped them). Therefore, I highlighted these areas when looking through the scripts (Appendix 6). McAdams' approach allowed the stories to be partitioned in a way that let me (as the researcher) consider the text in the context of intrapersonal and interpersonal aspects (Crossley, 2000a). McAdams (1993) suggested dominant themes would arise from this process. McAdam's approach allowed an empathic interpretative stance to be taken, prioritising the meaning participants constructed around their experience (Willig, 2012). It also provided a framework from which to draw out experiences, key moments, and scripts that underpinned the narratives and concepts of the participants' identities (Barresi, 2006).

Using the first transcript as a starting point, I began to identify themes, based on a narrative thematic structure (Reissman, 2008), documented in tables, accompanied by supporting quotes (Appendix 7). I reflected on my thoughts and feelings and the dynamics between myself and the participant during this process (Crossley, 2000a), making notes on the transcript and building on this with the other transcripts as I proceeded, moving back and forth between the core stories, transcripts, and tables, to retain context.

Throughout the analysis process, I attended research supervision groups at university, during which colleagues and I would read through transcripts (brought in by colleagues

from their projects) and give feedback of interesting and important observations within the texts. This helped me to practise the analysis process with data other than that collected in my project. I was also able to bring a sample of transcripts to these groups to get another perspective, by finding out from others what they identified as key ideas within the data I had collected. This helped to ensure their ideas were similar to what I was identifying in the data during my initial read-through of the transcripts (aiding reliability and validity). I began to create tables (Appendix 7) from the core stories and transcripts, starting to create sub-themes from key quotations in the tables, which, from my interpretation, seemed to resonate the most across participants.

During this time, I was preparing to speak at a narrative research conference, presenting the main theme I had started to develop, and the analysis process so far. It was useful to get feedback, making me think more about the data and questions around ethics, such as how participants might perceive my interpretations. Triangulation was important, once I had started to create tables (Appendix 7), I was able to bring some of this information to a narrative research group I formed with other narrative researchers. I went through some of my transcripts with them, showing them my tables and getting feedback as to whether the information could be interpreted in a different way, and whether my interpretations seemed valid. It was interesting to note observations made by others, which added to my understanding of some quotations. Throughout the process, I also discussed theme development with my supervisor. I found that discussing themes with my supervisor was helpful, and aided the process of clarifying themes, ensuring they made sense and were accurate in the context of the interviews, providing further triangulation. Due to the intricacies of the narratives, themes often felt interlinked. One discussion with my supervisor was particularly helpful, making a clear delineation in my mind between where the 'role of the hero' and 'setting boundaries,' crossed over and interacted, so that I was able to separate the roles adopted by siblings and resulting behaviours.

Writing up my findings proved challenging. Based on the ethos of narrative I sought to re-present the participants' experiences in a meaningful, transformative way (Squire, 2008), whilst simultaneously giving the participants a voice (Smith, 2008). Getting the balance between analysis and descriptive accounts was difficult. I was guided by previous narrative papers, and Crossley (2000a)'s advice, that, "in order to support his/her analytic findings, the researcher has to build up arguments and present evidence from the data set in front of him/her" (p. 104). This encouraged me to structure my analysis with the

inclusion of a thematic structure (identifying five key themes), whilst also weaving the extracts in a way that presented the participants' stories.

CHAPTER 4. ANALYSIS

Following the interviews with the six participants, the analysis section aims to highlight the 'how,' 'what', and 'why' of the narratives (Lieblich, Tuval-Mashiach & Zilber, 1998), using the research questions to guide this process. It attempts to describe my understanding of aspects of the participants' experiences within the context of their own identity and journey.

Previous narrative research guided me on how to present the analysis (Moran, 2017). I will split the analysis into two sections. First a version of the participants' core stories will be presented. This will allow the participant's narratives to be acknowledged and will preserve the individual stories of the participants. This fits with ideas that narrative analysis can be solely descriptive (Reissman, 2008). Secondly, general themes will be presented to capture some of the shared experiences and my observations, thereby also including an in-depth interpretive approach.

Following each narrative being presented, the following five themes will be discussed (guided by the research questions):

1. Theme one: Finding space – difficulty placing themselves within their own story.
2. Theme two: Confused narrative structure – wanting a resolution.
3. Theme three: Role of 'the hero' – developing an identity.
4. Theme four: Striving for boundaries and control.
5. Theme five: Survival guilt – experiencing blame, shame, and guilt.

Within the themes there is an initial focus on understanding context and the structure of the narratives. As the analysis develops, I investigate the form of the narratives and the function of them being told in this way, considering more deeply the 'why' (Earthy & Cronin, 2008). I use my research questions to guide this process. I reflect on my presence, using elements of my cultural background to interpret ideas posited by participants, embedding myself in the analysis, and using analytical bracketing to move between analytical perspectives. My aim is to interpret their reality through my own lens, shaped by my personal and professional background, and in doing so, help make sense of the complexities of the narratives (Gubrium & Holstein, 2009).

I conclude this chapter with my personal reflections and a summary of the main findings.

4.1 NARRATIVES

***Names and details have been changed throughout to maintain participant anonymity.**

Participant one (P1):

P1 is a White British female in her early 30s, living with her husband and two dogs; she hopes to have a child soon. She has a degree in psychology and works in the City.

Family set up: P1 grew up with her mother (a nurse) and father (an engineer), and an older brother, Jack*, currently in his early 30s.

Sibling substance misuse: P1 first became aware that Jack was misusing drugs when he was 18, whilst living at home, but he only admitted he was misusing substances (cocaine) in his early 20s. He had a highly paid corporate job in the City, but was fired due to the debt he accumulated on the company card. He was later offered other similar jobs (internationally) but accumulated debt, had a psychotic episode, and at one point was arrested for cocaine possession in a different country. However, he avoided prison. During this time, Jack was admitted to a mental health hospital and attended rehabilitation. Nevertheless, he was unable to stop taking the drugs for long and is currently still misusing cocaine, as far as P1 knows. P1 is in contact with Jack.

P1 began her story talking about when her brother started using substances. She recounted that the family realised substance misuse was a problem for him a couple of days before P1's birthday, following her brother being fired from a job. She later reflected that this follows a pattern; positive events occur for her, punctuated by crisis points for her brother. She conveyed some guilt around this. P1 remembered that her brother was admitted to hospital for rehab and talked about being offered family therapy. Following her parents being called *"enablers"* (P1, 85)[2] by a health professional, due to lending the son money (P1 estimated that her father had paid nearly £100,000 of her brother's debt over the years), the parents found it *"very very difficult"* (P1, 86) to engage. P1 only remembered going to one session of family therapy and did not *"feel like there was that much support, but I'm not sure if that's because it wasn't there or it was rejected by my parents"* (P1, 64-66). She recounted how, following rehab, her brother's substance misuse continued.

[2] Denotes participant number and line numbers quotations are taken from within their interview transcript.

Her brother was successful at his corporate job in the City but got fired following debt he racked up and was nearly sent to prison in a foreign country for cocaine possession. She recalled that at this point she was asked by her parents to postpone her wedding, so that her brother would be able to attend. This left P1 feeling resentful and angry that she was expected to change her plans, with her brother being prioritised. She recalled other instances when the family's needs have been compromised, or the family have been exploited by her brother. On one occasion P1's mother (a nurse) had to fly to another continent as the family believed her brother was physically ill, only to find that he was having a psychotic episode, as a result of recent substance misuse. Following Jack getting fired from another job, and having to pay the debt he had accumulated on the company card, P1's parents threw him out. P1 talked about the pressure she felt, that it was up to her to look after her brother (who moved in with her) after her parents felt they no longer could, *"I didn't blame them, but then I had no choice but to take him" (*P1, 189). Later commenting *"when the parents reject them, there's only the siblings left and you often feel that burden as a sibling"* (P1, 935-936). Her father suffered a heart attack, anxiety and eating issues which culminated in a *"breakdown"* (P1, 446) and her mother was psychologically impacted and had a breakdown also.

P1 spoke about the contrast between the success and bravery she admires in her brother. Having travelled extensively and engaged in many extreme feats such as climbing mountains and taking on physical challenges, she struggles to understand how these aspects can coexist with his substance misuse and deep vulnerability. On one occasion her brother phoned P1 from a country in Europe, threatening to kill himself. She spoke about the difficulty in managing such situations and moving from feelings of anger and resentment towards Jack, wanting him to stop his behaviour and feeling sorry for him as she feels he can not stop taking drugs. P1 described the communication difficulties in the family around the subject, not knowing if her mother and father had ever talked about her brother's substance misuse to each other, but stating that they talk to her individually about it, leaving her feeling *"stuck in the middle"* (P1, 308). She described talking to her friends about the situation but feeling like they find it difficult to understand.

The embarrassment, shame and secretive nature of the situation are all things P1 finds herself and her parents battling. P1 went on to speak about the guilt her parents hold, asking *"what did we do wrong?"* (P1, 516) although she does not believe they are to blame. The participant described constantly worrying whether her brother will *"either get put in prison or he'll die"* (P1, 428) and at the time of the interview he was due to

visit her home for a few days, which she was *"already anxious"* (P1, 769) and *"frightened a little bit"* (P1, 771) about. She said that she hoped he followed the rules and worried about him needing support; and feeling vulnerable. She said that she felt she had to be protective so as not to *"tip him over the edge"* (P1, 892) yet wanted to be *"firm"* (P1, 807) with him. Although she said that her brother loved her dearly and that all things considered they have an *"amazing relationship"* (P1, 805-806). She also said that, maybe, because he knows the participant will *"always be there so you know there's never going to be a rock bottom, I'll never see him out on the streets"* (P1, 814-815), it doesn't motivate him to change. At this point in her narrative she acknowledged that this dynamic with her brother might have to change if she has a child and needs to protect them instead. She recalled how the relationship with her brother currently impacts the relationship with her husband. She had lied to her husband in the past about her brother's actions and her husband does not like how her brother treats her parents. P1 does not want this unhelpful dynamic with her brother to spill over into the relationship with her future child.

P1 spoke about her struggles with trying to understand whether her brother's substance misuse is an addiction or an illness and reflected on the impact she believes it has had on her. She recounted that she believes that her brother's substance misuse has made her *"a massive control freak"* (P1, 528), left her feeling worried about *"spiralling out of control"* (P1, 138) (like her brother) and as a result she has never touched drugs and acts in a *"sensible"* manner (she is called *"Captain Sensible"* (P1, 538)). She went on to share her experience of stigma. She said that she *"find[s] it very uncomfortable if anything about drugs comes on TV"* (P1, 542-543) about substance misuse, in case *"people judge me because of it"* (P1, 543). She said that it was difficult to know where to get help and spoke about one of the barriers being that *"it goes in phases, it's not terrible all the time"* (P1, 611-612). She said of accessing help, *"you just never do it coz, I absolutely wouldn't look on anyone that's gone to counselling as a failure, but I would think 'oh it's not that bad, just get over it,' I got too many things going on when I'm having a fine time, or, you know, or if I finally get, go to the GP 6 months down the line when you get a session and you're like 'oh I'm alright now'"* (P1, 606-611). She reflected that when things are going OK she does not feel she needs help.

P1 also spoke about learning patterns in her brother's behaviour. She said that *"I always know when it's going badly because I won't hear from him and then the tipping point is he'll ask to borrow money"* (P1, 616-618). She said at that point her *"gut feeling"* (P1, 630) kicks in and his *"personality changes"* (P1, 631) informing her something is wrong,

whilst her parents deny the situation and *"try and put it to the back of their minds"* (P1, 623-624). She described reaching breaking point with this pattern, at times, and having mixed feelings about confronting the situation. On one occasion at Christmas, after not being in contact with her brother for a while, she confronted him in front of their parents. She recounted that she *"instantly felt horrific for ruining my parents' Boxing Day" "and thought 'I haven't ruined it, you've ruined it'"* (her brother) (P1, 658). She described it being normal for her brother to take *"the absolute piss"* (P1, 684). However, as P1 usually is *"so desperate to keep the family together"* (P1, 724) and is *"protective over [her] parents"* (P1, 680-681) she tries not to have an argument and confront the situation. P1 expressed a hope that one day her brother *"stays clean"* (P1, 832), but believes *"this will just be our lives forever and eventually he'll probably kill himself and that's horrific"* (P1, 833-834).

P1 voiced her motivation for participating in the study, sharing that she felt her story may be different from the norm and give a different perception of *"drug addicts"* (P1, 925). *"Drug addiction is something people don't typically talk about, I think, umm, when people think about drug addicts, they think of people on the street or you know, horrible squats and living awful lives"* (P1, 923-926). In comparison her brother had a *"high powered career"* (P1, 929-930) and has *"never stolen"* (P1, 927). She hoped that the research may *"put in place some support for people in the future"* (P1, 942). She concluded that the interview process was *"quite therapeutic"* (P1, 952).

Participant (P2):

P2 is a White British female in her early 40s. She has a degree in law and works as a police officer. She is married with two children.

Family set up: P2 grew up with a mother (who worked part-time) and a father (who worked for a well-known car manufacturer), and a younger brother, Danny (currently in his early 40s).

Sibling substance misuse: P2 found out that her brother had started taking substances (cannabis) when he was 16 years old and she was living with him in the family home, but only realised it had become problematic, with him misusing substances, when he was in his early 20s (which developed into crack cocaine and heroin use). In his youth, P2's brother obtained a part on a children's television programme and was offered a professional contract with a rugby team; however, due to the substance misuse, these

opportunities were short lived. In adulthood, he worked for a scaffolding company for a while but then turned to crime (theft), he has been arrested and been to prison multiple times. P2 is uncertain of her brother's current situation, but believes he is currently on methadone and has alcohol issues. P2 is not actively in contact with her brother.

P2 started her narrative by introducing herself as a police officer, a mother and a married woman. She described her early life, growing up on a council estate, she said they *"weren't rich"* (P2, 22) but always had *"food on the table"* (P2, 22). She described how she grew up with her mother, father and younger brother.

When recounting growing up, she talked about being close to her brother, remembering them always being together, until they started secondary school, which is when their relationship started to change. She attributed this change partly to her being 'geeky' and him being 'good looking' and talented at rugby, as a result they had different friends. She described that she was nearing the end of her teenage years when she first found out her brother was taking cannabis. P2 confronted him, but promised not to tell their mother as she thought he would stop. However, when she caught him smoking again, sometime later, she told their mother who went *"ballistic"* (P2, 85). P2 talked, with sadness and anger, about the great potential of her brother, in his adolescence. Describing how in his youth her brother obtained a part on a TV children's programme (during which time he was given access to money and drugs) and was offered a professional contract with a rugby team, however due to the substance misuse these opportunities were short lived. P2 described him starting to take cocaine with a girlfriend, getting arrested for fighting and therefore being in prison on P2's 21st birthday, with their mother refusing to visit him. There was a mistrust of her brother to the point that they locked the house to prevent him from getting in, but the neighbours (not knowing what was going on, would let him in). There were periods of time when P2's brother would not be in contact with the family (which felt like a relief for the participant). She described how, in adulthood, he was in a relationship and was arrested for domestic violence a number of times. Her brother worked for a scaffolding company for a while but then turned to crime (theft). She spoke about his criminal record; he had been arrested and been to prison multiple times. She described her mother as being a *"disciplinarian"* (P2, 30) and trying to tackle situations *"head on"* (P2, 349) whilst her father was more lenient and would be *"ignoring the situation"* (P2, 349). She even recalled, incredulously, how once, she thinks her father

obtained drugs for her brother, to stop him 'clucking' (drug withdrawal symptoms), as her father can *"never say no"* (P2, 671) to her brother. P2 described the impact her brother's substance misuse had on her career, when wanting to join the police force she was nearly told she could not, due to her brother's criminal history. They accepted her into the police force, but she was only allowed to work in areas he had not committed crimes. However, she heard from work colleagues about her brother's notoriety and they would often talk about him, which left her feeling embarrassed and compromised. She said it felt like she could not *"get away from him"* (P2, 505). P2 also said that her job prohibited her from having close contact with her brother (despite her ambivalence about wanting to have contact with him). P2 described that she would have to lend her parents money so they could give her brother money. She described situations (such as with work) where she felt punished for her brother's actions. This left her angry. She also experienced guilt and worry when her parents felt bad about her brother being on the streets. She recalled how, on one occasion, when he stayed at her parents' house, he slit his wrists and her parents panicked and did not want the neighbours to know. P2 said, *"I remember saying you selfish prick"* (P2, 482) *"if you want to kill yourself go ahead" (P2, 482-483) "but don't do it in their house"* (P2, 483). She tried to find positives in her experiences and reflected on how *"it sounds bad, [but it] had a positive impact"* (P2, 483) as she was able to later use this as an example in a job interview of how to cope in stressful situations.

P2 went on to recount further disruption caused by her brother's substance misuse. She spoke about how her brother's behaviour caused arguments between her parents. P2 recalled an incident when she *"punched [her brother] in the face"* (P2, 634), in defence, when she thought he was going to steal something from the family home. She described her mixed feelings; of *"disappointment, but it was also a relief"* (P2, 690) when he did not come to her wedding. She explained that lots of her friends are police officers and she did not want trouble on her wedding day. She recalled her parents having to hide alcohol at Christmas when her brother was on methadone and had substituted drugs for alcohol. She also spoke about the argument that ensued with her parents on that day, after making lots of effort which was then compromised by her brother. She stated that she finally voiced how she felt in that argument, telling her parents *"I've always been put on the backburner"* (P2, 773). She shared feelings of anger and resentment, *"I do everything right, I said, but no one cares about [my] feelings"* (P2, 782).

P2 went on to speak about her parents feeling shame, leading to breakdown in communication between family members. She said that her mother would not talk about her brother's substance misuse with her best friend or her mother (the participant's grandmother). This put a strain on the relationship between her mother and grandmother. She said that her father did not speak to other people about it as he was also *"worried about the shame"* (P2, 837). P2 shared, how in an attempt to counteract these feelings, she would tell her parents *"it's not your fault..some people just make bad decisions"* (P2, 834). More recently P2's mother started to talk about how upsetting the situation was for her. However, sadly, P2's mother died a couple of years ago from a heart attack. The participant spoke about the distressing nature of this event, exacerbated by having to tell her brother. She shared how she broke the news to her brother on the phone about their mother's death. He reacted by swearing and hurling verbal abuse at P2. The tragedy was further heightened, when P2 later found out that, a couple of days prior to the mother's death, her brother had rung her mother to ask her to be a guarantor for flat he couldn't afford. She learnt that, further to her mother refusing to be a guarantor, her brother had sworn at their mother, and that was the last thing he said to her before she died. Since then P2 said that her brother has threatened to kill her. Her father has moved in with her, her husband and children. P2 said that she felt worried about the safety of her father (her brother can be violent when under the influence of alcohol) when he was living alone and so invited him to live with her. This way her brother is less likely to prey on her father. They receive regular calls of harassment from her brother, asking for money.

P2 said she participated in the interview to cut down stigma (people feeling *"ashamed"* (P2, 1263)), *"it's good to talk about it,"* (P2, 1264) *"let[s] you know that you're not the only one, that every family has got their black sheep, and you know, no one's perfect"* (P2, 1265-1266).

Participant three (P3):

P3 is a White British female in her early 50s. She works as a family and carers worker in a substance misuse service.

Family set up: P3 grew up with an adoptive mother and father, and two adopted sisters: Anna (early 50s) and Nikkita (mid-40s). P3 also has three biological siblings she did not meet until adulthood.

Sibling substance misuse: Anna started taking drugs aged as a teenager, and P3 found out Anna was misusing crack cocaine when Anna was in her early 20s; they lived together on and off during this time. Anna suffered domestic violence in a relationship with a man (also misusing substances) who she subsequently had a daughter with (now in her early 20s). Anna did access support on one occasion, but continued to take substances. Anna stopped taking drugs five years ago to the best of P3's knowledge. P3 is in regular contact with Anna.

Nikkita was taken away from P3's family by social services and put in a care home, following this, she started taking drugs (cocaine) as a teenager. She has a son who is in his 20s (who developed a steroid addiction) and two daughters. Nikkita is still misusing drugs.

P3 spoke about her experiences growing up in an adoptive family. She said that she was adopted within a week of her birth and grew up with two other adopted sisters. She described this initial environment as *"loving"* (P3, 4). Tragically her adoptive father died from a health problem when she was still a child, which left her with *"a great sense of loss"* (P3, 17). She recounted that following this her adoptive mother remarried, with her step-father joining the family four years later. In her late teens her adoptive parents moved house, causing her and her sisters to become homeless. P3 spoke about developing alcohol dependency in her 20s after getting into a relationship with someone with alcohol problems. She recounted, *"I didn't know the dangers of it, it just crept up on me"* (P3, 50). She said that during this period she was not aware of her actions most of the time. She has been abstinent for over a decade now.

P3 recounted that her younger sister, Anna, started taking drugs at a young age. P3 found out that Anna was misusing crack cocaine when Anna was in her 20s. She recounted that at the time Anna was involved in a relationship where she was experiencing domestic abuse from her partner. She said that Anna did access support for her drug use on one occasion, but continued to take substances. Nikkita, the participant's other sister, started taking cocaine as a teenager, following being taken away by social services and put in a care home. P3 stated that within her narrative she would focus on Anna, with regards to speaking about sibling substance misuse, as Anna is the sister P3 remained closest to.

P3 went on to further describe the relationship Anna was in with a *"thoroughly horrible man"* (P3, 68), who was in and out of prison. She said Anna was very afraid of him and he was on crack cocaine. P3 believes he encouraged Anna to take crack cocaine. P3 contrasted this experience with that of her sister, Nikkita, being introduced to substances. She said Nikkita got into *"the wrong crowd"* (P3, 81) following being put in a home. She reflected on the *"sibling rivalry"* (P3, 84) between the two, with Nikkita feeling Anna *"was goody, miss goody two shoes and got away with everything"* (P3, 89-90).

P3 described having alcohol dependency at the time she found out Anna was misusing substances. At the time Anna denied her use of substances until she got *"stick thin"* (P3, 95) and *"finally admit it, but she she kind of wouldn't do anything about it"* (P3, 94-95). P3 described the harrowing experience of Anna's continuous need for help, *"[Anna] kept knocking on my door asking for help, asking for money"* (P3, 99). P3 recalled one incident when Anna was staying with the participant and *"was supposed to be looking after me"* (P3, 101-102) during her alcohol detox. Instead the P3 recounted that Anna managed to get in contact with a 'dodgy friend' of the participant's and borrow money from them to buy crack cocaine, leaving the participant in debt (unbeknown to her).

P3 expressed often feeling stretched and said that she remembers standing at her front door telling Anna *"I can't do this anymore"* (P3, 111), *"you're ruining me, you're ruining yourself, you're ruining your daughter's life"* (P3, 112). The participant recalled her sister crying at this point and, as a result she felt guilty, *"you feel neglecting emotionally aren't you, cause it's your problem"* (P3, 113-114). P3 spoke about worrying when Anna was not around *"because she's got a way of making me feel"* (P3, 118), *"when she says things to me I feel guilty and I feel ..bad because I think I've always been, not always been, but I am the older sister, I've always been 'the looker-after'", "she's always kind of relied on me"* (P3, 122). P3 spoke about feeling responsible for her sister and finding it difficult to say no, feeling conflicted. P3 expressed that at one point she felt *"I need to walk away, this is getting me wrapped up in sorts in my head"* (P3, 125). She spoke about Anna going away for a couple of weeks, and ringing her, saying, *"'I'm losing everything, I've gotta go and get help'"* (P3, 126-127). As a result, P3 directed Anna to support services. She described that despite Anna accessing services at that time, she was not ready to accept professional help and so only attended four counselling sessions. P3 contrasted this to four years ago when she felt Anna was ready and better able to access support. P3 spoke of the difficulty in letting her sibling go and giving her space to be independent, *"I do believe you can be there, sometimes you can be their worst enemy as well, so I feel that I*

did the right thing even though it felt wrong, at the time, I felt I can't I just can't do this anymore, it's doing my head in" (P3, 143-145).

P3 reflected retrospectively (in her role as a 'mother figure') on Anna's progress. She said has *"done so well, [but] she is still quite emotionally needy"* (P3, 154-155). P3 said that following the death of Anna's biological mother, it caused P3 to *"become even more of a mother figure to her [Anna]"* (P3, 161-162). She talked about the support Anna needs now, following the death. P3 described Anna as still not being ready to talk to someone about it, *"it's all too raw and not gonna, poking about with something, she shouldn't, I feel like her mum, I'm sorry"* (P3, 530-531), continuously identifying as a mother to Anna.

P3 went on to refer to other life events her and Anna have endured; making contact with P3's biological mother and Anna's biological family and rescuing Anna from her abusive boyfriend, commenting that *"[Anna] doesn't see the danger signs in relationships because the need to have someone in her life is greater"* (P3, 198-199). P3 then went on to mention the impact Nikkita's drug use had on her children, with the children having developed addiction problems themselves. She shared guilt about the outcome of Nikkita's children's lives, and that the family were limited in the help they could provide. She said, *"although we wanted to help we didn't feel we were able to"* (P3, 215-216).

She spoke about the dynamics between her and her sisters, *"I was always the oldest and always the most responsible"* (P3, 406), they *"were quite scared of me, not sure why"* (P3, 420). She described herself as being *"on the outskirts"* (P3, 428-429). *"I think I learnt to be alone because, those two were just, I was here and they were there"* (P3, 438) *"that probably made me angry"* (P3, 439). P3 she said that she *"felt like I'd been pushed out"* (P3, 440) by Nikkita, as her and Anna had been close before Nikkita joined the family. She commented that when Nikkita was sent away for a while (care homes) P3 had not wanted Nikkita to come back. P3 felt that her and Anna would have been closer if Nikkita had not returned, feeling that Nikkita was a bad influence on Anna. P3 described having a very different relationship with Nikkita than Anna, *"although I love her, I don't like her very much"* (P3, 219-220). She spoke about conflicting feelings towards Nikkita, *"we're just very different"* (P3, 240). P3 said that only recently has she realised that Nikkita *"was very damaged from a young age, I don't know if she was able to fit in if you like"* (P3, 408-409). She spoke about Nikkita being *"missed out completely"* (P3, 416), with Anna taking the role of *"the baby"* (P3, 416), despite Anna being older in age.

P3 continued with her narrative, trying to make sense of how all of the siblings went through a period of dependency with some type of substance. She said that perhaps it is related to attachment difficulties and unsavoury experiences as children. In respect to her own alcohol dependency she reflected on her experience, *"back then, I think I played the victim for a long time, myself in my own addiction, I was a victim for a long time and I would never take any responsibility and [was] quite angry"* (P3, 290-291). *"So I think I've matured finally, and can look at it, in a different way, in a way that I think maybe I wouldn't have done before"* (P3, 293-294).

P3 went on to speak about the importance of people accessing support, maintaining boundaries with loved ones and not *"enabling"* (P3, 481). She reflected on her own experience in relation to the experiences of the people in the group she runs (which supports family and carers). *"You know there is no one thing right now that will stop [loved ones misusing substances], so I know that you don't get answers, you can talk it through, you can behave in a different way to effect loved ones, yeah and I think that's kind of what I did, cause that was the last straw for [Anna], me walking away, what she'd lost..she was losing her looks, she was losing weight she was losing money..her teeth were going, so me walking away was kind of –probably the right time and the right thing to do"* (P3, 311-317). At the same time she acknowledged how much she struggled with that decision, and *"agonised about it"* (P3, 319). She shared that she worried what might happen to her sister and was *"full of fear,"* coming close to phoning Anna multiple times. The participant also went on to speak about her difficulty in previously opening up to others about her situation, fearing that they would not understand.

At the end of her narrative P3 shared that she feels more research like this needs to be done, *"it's been interesting actually talking about it all, brought it [all up], when it's kind of, there's a few, I guess when you talk about something you get.. a few realisations if you talk about it in a different way"* (P3, 536-538). She reflected that she found the process helpful and that talking about it was less difficult than she imagined. *"I think it does seems quite a while ago to me now, although occasionally I do worry about her, but I've moved on a lot and that and she's moved on a lot, so, it's all good, and talking about it…it's kind of good actually … it didn't upset me at all, although my voice went … I don't know whether that was …psychosomatic or whatever you call it, yeah… erm, yeah no I'm fine"* (P3, 546-550).

Participant four (P4):

P4 is a British Caribbean male in his mid-40s. He works as a police officer. He grew up in the Caribbean, raised by his grandmother, with his two younger brothers (Roy and John). P4 came to the UK when he was in his early 20s to live with his parents, and his brothers later joined him. P4 is now married with children.

Family set up: Growing up, P4's grandmother and other family members supported him and his two younger brothers. Now, his middle brother (Roy) and his youngest brother (John) have children.

Sibling substance misuse: When John was in his 20s, P4 noticed John's substance misuse (cannabis), due to changes in his behaviour and mood, including paranoid thoughts, psychotic symptoms, and aggressive behaviour. John lived with P4 for three years during this time. John joined the army and had inconsistent employment. He stopped smoking cannabis over a year ago, and now lives with his girlfriend. P4 is in contact with John.

P4 started his narrative describing his experience of growing up in the Caribbean with his two younger brothers and the rest of his family. He described his younger brother, John, as *"the problem one"* (P4, 11). Explaining that when John came to England he started to sell and take cannabis, in contrast to himself, who he describes as *"a disciplined person"* (P4, 30). He spoke in a matter-of-fact tone throughout his narrative. *"You know in every family there [is] always a black sheep"* (P4, 30-31) *"one that gives trouble"* (P4, 33), *"him who started with all the problems"* (P4, 33). P4 explained that his life in the Caribbean was very different from being raised in England, *"you had to stand up strong fo-for yourself as a child at school"* (P4, 37-38). He described growing up in a simple environment, eating healthy food and having *"people always around us that look out for us: uncles, aunties"* (P4, 46-47). In contrast to England, he said that although cannabis was around in the Caribbean, people saw it as *"no big deal"* (P4, 56-57). P4 spoke about him and his brothers being warned against cannabis use in the Caribbean by his grandmother, and that it only became a problem when John was introduced to cannabis in England. John became involved *"mixing it and selling it"* (P4, 68), as it was *"readily accessible in London and the group of friends he was with"* (P4, 74-78).

P4 described how the change in John's behaviour became difficult to manage. *"Well, you know, he he get more aggressive at times, you know, no one can talk to him, you know,*

the paranoia, you know, and the the psychosis and all that, you know, just take over his life, you know, you know and if he doesn't get what he wants he will, he will, people cannot live with him " (P4, 85-89). *"You have to involve people you don't want to involve like pastors at church"* (P4, 93-94) and *"we don't go to any therapist or anything like that because we don't believe in those things"* (P4, 96-97). He felt it was *"a waste of money telling people your business who don't care"* (P4, 98). P4 instead spoke about taking on the responsibility for John, he said he had to *"sort of guide him and educate him better"* (P4, 106). He explained that he *"felt responsible"* (P4, 139) for his brother's substance misuse. This was because P4 had got John a job at the barber shop where John started mixing with people who introduced him to selling and taking cannabis. P4 went on to speak of the shame and stigma he experienced, leading to secrecy and not believing anyone would support him. He also spoke about the sacrifices he made in his personal life to help his brother (including alluding to the strain on his personal relationships). *"You have to stop what you're doing to assist him"* (P4, 161), *"because he was my priority, he was my brother…and I have to make sure my brother is fine"* (P4, 166-168). P4 also described how he supported his brother in overcoming his substance misuse. *"You have to be consistent with people like them, because once you leave them and they think that you don't care, they will just break the trend of what you're trying to achieve fr-from them"* (P4,143-145). He said that sometimes supporting his brother *"was pain-staking"* (P4, 183).

P4 talked about the *"memories of [his] brother"* (P4, 176) before John's substance misuse, as being important. Especially having grown up with John in the Caribbean, with *"no mother and father all the time"* (P4, 193) (as his parents were in England). *"Togetherness"* (P4, 198) was very important to P4. He contrasted the way of life in the Caribbean as being tougher than in England. *"You don't grow up weak"* (P4, 209), *"people even say now that I'm a hard person in the way I think and the way I outlook my life but you know being the way I am, coming from where I come from, that is how I was brought up"* (P4, 211-213). *"You stand up for yourself and you have your brothers to protect around you"* (P4, 219-220), *"you grow up as a team"* (P4, 222). He described his role as previously being that of the leader in the family. *"I think the Head role I've given it up to to one of, my middle brother, but I used to have the head role, you know"* (P4, 281-282). P4 spoke about John's cannabis use in relation to harder drugs, *"we're just lucky that it wasn't the hard the hard stuff"* (P4, 364) and the anomaly John presented in the family, with the rest of the family being *"clean skin people"* (P4, 392) (no other

members used or sold drugs). P4 reiterated the importance of *"the family sticking together"* (P4, 374) multiple times in his narrative. He said that he believes family support is what aided his brother's recovery, alongside the discipline John developed when he briefly joined the army.

P4 shared that his own emotional support came from family members, as he only spoke to them about the situation. *"I have good friends"* (P4, 524-525) but *"people have so many problems already you know you don't want to be depressing them with more problems"* (P4, 635-636). He acknowledged that he did not blame his brother for his actions, *"life is a struggle, life is a challenge you know, and a struggle it doesn't look so bad, one of my, one of them, you know, [John] has problems with, you know, with his missus all the time and so I have to guide him as well, you know, but I myself need guidance as well, you know, because no one, everybody's a human being, you know, we all umm, we all umm, we all there for the takings, we can be vulnerable at times, as human beings we make mistakes we learn you know"* (P4, 513-519). He described that John *"hasn't turned out bad"* (P4, 535), *"he's fine now, you know he's still [got] a bit of temper, err what can I say, he's still a bit of a mouthy person you know, he get into a little bit of trouble now and again he-he well he tried a few years in the old army, you know, that sort of cooled him down a bit you know yeah yeah and he's making better of his life now"* (P4, 547-550). P4 conveyed feeling hopeful for his brother's future, with the family supporting him. *"The family support, you know, is the most important, that is the foundation of any help you can give to anyone, to know that, someone cares about them.. that's the foundation, you know, it doesn't matter doctor, psychiatrist. It doesn't matter where you try to go, how much help you get, how much medication, you take a note that the family support is the most important thing..to show them that you care and from that they will get strength from that"* (P4, 604-611). P4 accepted that John may continue to need support from him. On being a role model to his brother he said, *"it's like you have a child at home you're strong a father, you know, I need, you think your child will get strength from you, if your weak person, they will get the weakness as well, a child, they they they learn what they see"* (P4, 613-615).

P4 concluded that his hope for this research is that *"it will probably just educate people you know an-on how this world is on how substance misuse is, you know, I hope you can help counsel these people who have these problems, mm, yeah, so. You know which I hope it will, yeah, so it's not really a problem for me to talk about it, as I said, you know, things,*

you know, I can just talk about things and just take things back out and bury it, I don't, I don't worry about it" (P4, 658-662).

Participant five (P5):

P5 is a White British female in her mid-20s, currently completing an undergraduate degree in counselling. Growing up, her father had a back accident, which resulted in him being diagnosed with depression. She became a carer for him and received counselling from a young carers organisation. P5 now lives with her boyfriend.

Family set-up: P5 grew up with her parents and her older mixed-race brother (Kevin, early 30s), who is adopted.

Sibling substance misuse: Kevin started misusing cannabis at 17 years of age, which was evident to P5 due to his more extreme behaviour. He stopped smoking cannabis five years ago, and he now lives with his fiancée and is employed. P5 is in contact with Kevin.

P5 explained that her initial reaction to seeing the advertisement material for the study was that this research did not apply to her, but once she had digested the information she realised that it did. She described her father adopting her brother at a young age. She said he was *"as good as gold"* and *"getting straight As"* (P5, 23-24) until his teenage years, when *"he was just a nightmare"* (P5, 24-25). *"He'd lose his temper over things, he's really selfish and inconsiderate,"* everything *"was exactly how he wanted"* (P5, 29) as *"he was just focused on his space and what he wanted to do"* (P5, 32). P5 contrasted this with herself, *"I've always been quite considerate of other people"* (P5, 33), whilst Kevin would blame others when he got into trouble. She recounted when her dad first found a 'joint' that belonged to Kevin; *"a lot of the time I'd just be up in my bedroom or watching TV, aware that dad and Kevin was shouting at each other"* (P5, 49-50).

P5 spoke about the changes to Kevin due to substance misuse. *"He didn't want to get a job or do anything with his life,"* (P5, 71) he got *"more and more skinny because he wasn't feeding himself"* (P5, 73). She said he got *"more and more aggressive and abusive"* (P5, 74), when he started using more *"he was getting paranoid and thinking that people were out to get him"* (P5, 115-116). P5 spoke about an incident when Kevin was disrespectful to her parents, *"I can tell mum and dad are a bit, like, taken aback"* (P5, 83), and so she tried to step into the parent role by telling him off, *"but it escalated*

and he ended up shouting at me" (P5, 87), saying *"you're just shitty because you didn't pass your driving test"* (P5, 88). She spoke about the most emotionally impactful incident related to Kevin's substance misuse. *"I had pulled him up on being rude to mum, in front of the guests"* (P5, 99-100), *"I was just so pissed off with him"* (P5, 102), following this she overheard Kevin saying that she was not his real sister, *"that was the worst of what happened when he was using"* (P5, 107). Despite the difficulties, she stated, *"but you know we're still a family"* (P5,113).

P5 could not recall when Kevin first started misusing substances, instead, *"[she] just gradually sort of put the pieces together"* (P5, 139-140), hearing snippets of conversations between her parents. She said there *"was never an explicit conversation about 'your brother's doing drugs'"* (P5, 143-144) and spoke about the lack of communication around the subject. *"I don't recall ever, whilst he was using, talking to mum and dad about what was going on, it was all kind of overheard conversation and and snatches that I picked up here and there"* (P5, 240-241).

P5 said when she found out Kevin was misusing substances she just thought *"oh it's just another thing that he's doing that's fucking stupid"* (P5, 154) and *"let Kevin be the naughty child, let him get on with making a mess of his life"* (P5, 156-157). She went on to describe how the substance misuse impacted her parents, *"it stressed dad out maybe more than he let on"* (P5, 163) but her mother was *"working a lot"* so they *"didn't really see a lot of mum"* (P5, 167-168). Her father had a back accident so could only do voluntary work, *"I don't really know how mum dealt with it"* (P5, 172-173). She shared the hidden and mixed feelings the family had. She said that once Kevin had stopped misusing substances, her mother told her *"you know it pains me to admit it but I dreaded him coming over as well, I actually dreaded seeing my son because I didn't know how it was going to be, um, but I didn't want to kick him out of the family because he's my son, I can't just get rid of him because I don't agree with his behaviour"* (P5, 213-217). It was not until after Kevin stopped his substance misuse that the participant and her mother shared a conversation about the *"dread"* (P5, 211) they both experienced when he would come over for Sunday dinner. *"It was just so awkward and you never knew what kind of mental state he was going to be in"* (P5, 212-213).

P5 also shared her own views of cannabis, *"cannabis isn't exactly, you know, it's not a hard-core drug"* (P5, 148-149) and that she learnt, through her experience of the drug, *"recreational use isn't necessarily a bad thing"* (P5, 177-178). But said of her brother, *"the way that he was using when it was problematic was a problem, it was an addiction,*

he had to have it and if he didn't have it then he suffered mentally and physically for it, so yeah, I think, I learned more, as I got older" (P5, 181-184).

P5 also shared the impact Kevin's substance misuse had on her relationship with him. It was *"another brick in the wall between us that kind of stopped us from having anything in common"* (P5, 189-190). Later she talked about it connecting them slightly when she asked her brother to get some weed for her then boyfriend, however even at that point the relationship between P5 and Kevin *"was still a bit strained"* (P5, 199). It was not until after the misuse stopped *"that we were really able to have a decent relationship"* (P5, 200-201) and a *"proper conversation"* (P5, 202). P5 does not completely blame Kevin's substance misuse for the change in their dynamic, and also attributed it to the transition into adulthood, *"so the dynamic had kind of changed naturally"* (P5, 415). When Kevin was misusing substances, P5 described *"disappointment"* (P5, 248) at his behaviour, and *"jealousy"* (P5, 250), *"jealousy of the attention"* (P5, 268) he received from their parents. She spoke a lot about feeling Kevin received lots of attention during their adolescence. Despite how much she tried to be a *"good child"* (P5, 264), she instead felt neglected and isolated in comparison to Kevin. She described the counselling she received from a young carer's organisation (in relation to being a carer for her dad at the time), being a good source of support, as she felt she could not talk to friends about *"a brother who's a druggie"* (P5, 281). She shared that it was a difficult time as she was also being bullied at school for being overweight.

"I don't know what the turning point was for him" (P5, 294), P5 shared, however she also said that she saw a change in Kevin's behaviour once he had stopped the substance misuse. She recounted that *"he was a lot more kind of motivated to kind of get a job and to get a career he'd be happy with"* (P5, 327-328), *"there wasn't this kind of stress and this anger"* (P5, 346-347). When he was *"craving"* substances *"he was a completely different man"* (P5, 348). She recalled, at the time of his substance misuse, cutting contact with him for a while, as *"why would I stay in contact with him if he's wasting his life and he's this kind of paranoid asshole basically"* (P5, 361-362).

P5 recalled that she attributed the substance misuse, at the time, to *"Kevin being selfish in a new way"* (P5, 412). *"Everything was very much as it was because his behaviour had always been very selfish, so we had always adapted around him being selfish, like I say, from his early teenage years"* (P5, 408-410). She contrasted this to the relationship they have now, *"I feel like I have a brother now"* (P5, 428), *"I love him to bits now, erm so the relationship between us is a lot stronger"* (P5, 429-430).

In retrospect she said *"I wish I hadn't been kept out of it, because I did feel very much like it was sort of like swept under the rug, and you know it's not my problem to deal with because I'm the sister and the daughter so she doesn't have to know about all this, umm, so yeah I do kind of wish I'd been involved in some way"* (P5, 436-440). Whilst contradictorily stating, *"it didn't have a huge effect on me at the time anyway"* (P5, 441-442). Referring back to the counselling she received from the carer's organisation, she said, *"it was just a space that was one hundred percent for me"* (P5, 449-450), to talk *"with somebody who didn't really know my family, didn't know my friends"* (P5, 451). *"Reflecting back that was really valuable for me because I- because like I say I felt like my family didn't really give me the time for me"* (P5, 452-454). P5 spoke about being unsure what her parents might have found supportive at the time, maybe something *"educational"* (P5, 359), but *"because they didn't really talk to me about it, I don't know, how they felt about it, so I don't know if they really needed a lot of emotional support"* (P5, 459-461).

P5 mentioned the extended family having mixed views about Kevin's substance misuse. She described that Kevin was the favourite on her mother's side of the family and so those family members were *"nonchalant about it"* (P5, 473). Whilst the father's side of the family favoured her. She remembered a vague conversation between her uncle and mother, with her uncle telling the mother to be less harsh on Kevin, as her mother did *"silly things"* (P5, 473) growing up too. P5 said her parents did not have many friends and does not know if her mother spoke to work colleagues about it.

Later in the narrative, P5 spoke about the difficulty in connecting with her emotions. *"I bottled it up for a really long time because, because it, that's how it'd been dealt with because it had just been swept under the rug and not really talked about"* (P5, 499-500). She spoke about having personal therapy as part of her current training as a therapist and feels this is helping to process her experience. P5 said that she learnt, through therapy (in relation to her childhood; with her mother working often, father having depression and Kevin's substance misuse) *"it was OK to be angry at them for those things, even though I know logically they did the best they could, it's OK to have negative feelings towards your family and that was a real kind of breakthrough"* (P5, 506-509). *"It took a while to process that"* (P5, 509).

P5 shared advice she would give to others in a similar situation, *"talk to the family, ask questions, don't let them shut you out just because they don't think that you're involved in it, you're involved whether they think you are or not, so, so speak up and find out and*

..and you know ..don't let yourself get shut out of that situation because it affects the whole family. It's not just..the immediate people involved." (P5, 518-522). She shared what motivated her to participate in this study. P5 said that having to do interviews herself, for her own course, she knew how difficult the recruitment process is and wanted to help. She also said that she felt her story may be different and may *"give some people a bit of hope that it could happen to them too"* (P5, 616- 617) (that their sibling could stop misusing substances).

Participant six (P6):

P6 is a Black British female in her late-30s. She works as an administrator for the police. She is married and has two children.

Family set up: P6 grew up in a household with her mother and father and three older sisters: Karen (early-50s), Sharon (mid-40s), and May (early-40s).

Sibling substance misuse: P6 remembers Sharon starting to take weed and other drugs when she was younger, but it became a more serious problem that could clearly be defined as substance misuse (cocaine) about 12 years ago, soon after Sharon's ten-year-old son committed suicide. During this time, P6 lived with Sharon in the family home with their parents for about three years. A couple of years later, Sharon had a daughter. Up until that point, P6 described Sharon as unstable, but being able to retain employment. Social services were involved with the care of both of Sharon's children. Sharon accessed support from forensic services. P6 is currently in contact with her sister, but is unsure if Sharon is still misusing drugs.

P6 started her narrative remembering back to when her sister, Sharon, started to misuse cocaine. Substance use became a problem when Sharon's adolescent son committed suicide, especially when Sharon moved back home with the participant and her parents. A couple of years later Sharon had a daughter. Up until that point the participant described Sharon as unstable, but able to get work. P6 explained that social services were involved with the care of both of Sharon's children and that Sharon accessed support from forensic services.

P6 spoke about Sharon being in trouble often when she was younger; at school (suspended, expelled), smoking weed and engaging in petty crime, always being *'the*

black sheep of the family' (P6, 57). She described there being *"something missing"* (P6, 146), as Sharon was so different to the other sisters. P6 spoke about Sharon being banned from her son's school for being *"one of those mums that go down the school and kick off every minute"* (P6, 172). She said that Sharon's son got moved around schools and maybe saw things he should not, including domestic violence and drug abuse. P6 questioned who was to blame for his death. She empathised that the death of her nephew was a tragedy for the whole family and so it must have been unimaginable for Sharon, suggesting this was a catalyst for Sharon's drug misuse. P6 indicated that Sharon was doing *"quite well"* (P6, 264) before her nephew died, but that the substance misuse became worse (was used as a coping strategy) following this. However, she also acknowledged that the substance misuse could not be blamed solely on her nephew's death. P6 spoke about the change in the relationship between herself and Sharon. She identified a *"role reversal"* (P6, 254), with Sharon asking her for money, and found it quite confusing as the younger sister, which made her start to see Sharon *"in a different light"* (P6, 253), *"I just didn't know who she was"* (P6, 255). P6 spoke of the financial burden on her parents who had to pay Sharon's rent arrears, despite Sharon later losing the house anyway. She went on to talk about mistrust of her sister, knowing that *"something's not right"* (P6, 269) when she would ask for money, but *"wanting her to be telling the truth"* (P6, 272) and so colluding with Sharon's lies and false reality.

P6 said that all of the sisters noticed the changes in Sharon and so met up to discuss it. They decided to have a meeting with Sharon to try and help her. However, this turned into an argument, as Sharon could not accept what was being said. *"I suppose if you're not ready for help you're not going to take it"* (P6, 336-337). P6 conveyed that she and the rest of the family wanted to help Sharon but were unsure how to, *"we did try"* (P6, 338).

P6 shared that when she was living at home she would protect her parents by telling them not to give Sharon money, as Sharon believed that their parents had lots of money, so would often ask them to borrow some. Due to P6's intervention her parents have now stopped giving Sharon money, *"they had to put a foot down, otherwise they would have been taken for a ride"* (P6, 358). P6 said that the family were *"disappointed"* (P6, 354) in Sharon when they found out about her substance misuse being the motivation for asking for money. P6 also said that whilst her parents do not lend Sharon things anymore, as she will not give them back, Sharon interprets this as being *"treated different"* (P6, 379). P6 spoke about knowing Sharon smoked marijuana before her parents did, *"us*

siblings probably saw it more," she stated that *"they're not so clued up about certain things"* (P6, 448). P6 said that she *"felt sorry for [her] mum and dad"* (P6, 503), feeling, during her upbringing, that *"I don't think they've done anything wrong"* (P6, 504), but struggling to know if the drug use was a choice for her sister. *"I dunno if it's [her] choice"* (P6, 869). She reflected that if the substance misuse was due to upbringing *"all of us would be like that or more of us"* (P6, 505). *"It's hard to pinpoint where, where it all went wrong"* (P6, 848). *"I think with the drug abuse and stuff, I think it's changed her personality as a person"* (P6, 645). She spoke about looking up to her sister when she was younger, as Sharon was the second eldest, but now *"I don't see her as a role model"* (P6, 609).

P6 spoke about the changes in her sister due to substance misuse. This included the change in Sharon's appearance, *"she lost a lot of weight"* (P6, 513) and behavioural changes, such as her sister becoming paranoid, agitated and angry. *"People started to notice"* (P6, 455), *"if we can see it then other people can see it, so it was like, yeah it's hard"* (P6, 522). P6 spoke about not talking to people about it but feeling ashamed when others found out through Sharon's actions. For example, Sharon started borrowing money from cousins and did not give it back, so the cousins contacted Sharon, *"it was quite embarrassing"* (P6, 488). She also said that Sharon *"used to be a prolific shoplifter"* (P6, 526), which local people in the community became aware of. In her narrative P6 highlighted a significant moment for her. She works for the police and recounted that when looking through case papers she undeniably found that Sharon was misusing substances. She shared the difficulty of not being able to tell anyone (as the case papers are confidential). *"It was there literally in black and white"* (P6, 534), *"it wasn't a shock..just you can't lie to me anymore"* (P6, 538-539). *"You kind of want to believe"* (P6,548), *"I don't know if it was a good thing or a bad thing"*. She spoke about her mixed feelings, thinking *"I'm not going to take your shit anymore*", but also, *"I think I probably wanted to have that reservation, that she could be telling the truth"* (P6, 559). Her experience included disappointment at no longer being able to deny reality, *"even though I knew it was, it was less of a hope"* (P6, 562). She spoke of wanting to hold onto that small piece of hope, *"I kind of hoped that 20% would stay there"* (P6, 566), so that she could retain *"like a bit more respect for her"* (P6, 566). Retrospectively she said that her other sisters, *"the elder ones knew"* (P6, 581) already that Sharon was misusing substances.

P6 shared more about the challenges faced when confronting Sharon about her substance misuse. *"I don't know if we could have done more, we probably could've"* (P6, 583) *"but if everything's going to turn into an argument"* (P6, 584) *"some things are better just left than fuelling"* (P6, 587), *"how do you, do we approach [Sharon], do we not say anything"* (P6, 521). She concluded that *"everything just turned back in on us"* (P6, 590), *"she'll make you feel bad, like basically it's your fault"* (P6, 597). *"I mean after a while, to be honest I just gave her a bit of a wide berth"* (P6, 601). P6 said that she is not sure if Sharon is still misusing drugs, *"I don't think she's still on it"* (P6, 696).

P6 went on to talk about the implications on Sharon's daughter. With responsibility being passed onto the family to look after Sharon's daughter, due to her Sharon's frequent *"disappearing acts"* (P6, 809). She recounted Sharon missing her daughter's first day of school. *"It becomes a pattern"* (P6, 771), *"it affected all of us because we had to kind of like help"* (P6, 784).

P6 spoke about *"the uncertainty I think, of not knowing what's going through [Sharon's] mind, I don't know, I don't know..emotionally, um, I think I've been alright, I just you know, you just worry, it's more just worry for her because you don't know if you're going to get the call one day"* (P6, 850-855), especially as her sister was previously suicidal. She continued to talk about the emotional turmoil she feels in relation to Sharon's substance misuse. *"It's a hard one, so emotionally kind of all over the place, you have ups and downs, sometimes you think, 'you know what I can't be bothered, I'm just going to live my life, if that's what she wants to do then fine', and then another day you think 'what can I do?'"* (P6, 870-874).

P6 talked about looking to the future, that Sharon is now attending university *"we didn't actually think she'd last"* (P6, 705) but, *"we will never give up hope"* (P6, 706). She spoke about the ambivalence of not knowing what will happen with her sister's substance misuse in the future. *"There's certain aspects that she'll probably never lose, coz that is just her"* (P6, 709) and *"she will always do silly things..that's just part of her character, but how far she takes it is you know, a different thing"* (P6, 714). She concluded, *"hopefully the future's bright"* (P6, 721).

When reflecting on what support P6 would have liked to receive, she said of her family, *"we were kind of like our own support network"* (P6, 907), but admitted she was unaware of support available for family members. *"I wouldn't have known but I don't know if I would've looked"* (P6, 912-913), *"because I don't think the problem was mine even"* (P6,

915), *"the problem was her"* (P6, 917). P6 did consider that if she did not have so many family members to speak to *"I might have looked outside of myself"* (P6, 922). She recounted a story of recently meeting someone that she knew, having previously noticed their sibling may have substance misuse issues. She approached the person asking, *"I don't want to say too much, you know, but is he alright?"* (P6, 957-958). She said that by sharing her experience of Sharon with this person, it helped them open up about their own experience. P6 said she hopes to remain in contact with them to help support them. She said of Sharon's substance misuse, *"we're going to have it for life basically, it's gonna stick with us for life, but, we have to kind of like crack down on the giving money and stuff"* (P6, 965-967). When considering advice she would give to others she said, *"I would say definitely stop giving them money"* (P6, 990) *"probably try and not to like lose connection with them," "it can make you worry even more," "try and keep some kind of link somewhere"* (P6, 991-996). *"That's what worries you, especially if they go like off the rails or go missing, like you wanna know"* (P6, 999). P6 also reflected that *"talking about it is good"* (P6, 1004), *"I found speaking with my sisters better than speaking to my mum and dad"* (P6, 1008-1009). P6 said she would use the support numbers I gave her (Appendix 5) in the future, for further support. Reflecting on the interview she ended, *"it's probably taken a weight off my shoulders, that I didn't know I had to be honest"* (P6, 1031-1032).

4.2 THEMES

Q1. What are the narratives of these participants (including how they structure and convey their story)?

4.2.1 A unique case: Finding space

Each participant's story represents a unique experience of residing within the family system. For many, this was the first time they had placed themselves within their experience or spoken about it. A few participants recounted discussions between family members in which, if it was spoken about at all, the sibling who was misusing substances was positioned at the centre of the story. P5 commented that her first thought about the study was: *"Oh, that doesn't apply to me"* (P5, 3–4), an idea that was reinforced by other participants. P6 remarked that the experience of the interview had *"probably taken a weight off my shoulders that I didn't know I had to be honest"* (P6, 1031–1032).

From a place of not identifying the experience as theirs, it proved challenging for participants to share their stories with me. When faced with the opening interview question: "Tell me about your experience," most participants looked to me for advice or direction, often responding with a version of: "Where do you want me to start?". Because of the artificial nature of the interview, participants may have been unsure about what or how much information to share. However, in the context of this study, it seemed that other factors were involved. One participant highlighted the complex nature of talking about her experience when asked about it by friends: *"I'll be like, 'same, same old situation' because I can't be bothered to talk about it, it's not that I don't want to, I just think 'uhh.. where do you even start?!' Like now talking to you I'm like, 'where do I start with this?' I don't even know"* (P1, 355–359). Her reflection suggests a plethora of emotions, including feeling stuck, tired, overwhelmed, and confused.

Participants explored other possible contributing factors to their previous silence. They stated that they did not feel heard or important: *"I've been always put on the backburner"* (P2, 774), *"no one cares about [my] feelings"* (P2, 784). They did not want to talk about it because it *"hurt! It hurt sometimes when you talk about things, it's-it's reliving something"* (P3, 347). There was a fear of burdening others: "*You don't want to be depressing [people] with more problems"* (P4, 639–640), and of perceiving others as not being able to understand their experience: *"You're not in my head, you don't have to live this*" (P3, 336). Worries about stigma were evident: *"Being a teenager is hard enough without telling your friends that you've got a brother who's a druggie"* (P5, 280–281). In addition, the secrecy and lack of communication within the family around the subject, the result of shame and embarrassment, made it *"the elephant in the room"* (P5, 226).

When invited to share *her* story, P1 starts by introducing her brother: *"so my brother's obviously three years older than me"* (P1, 10). This again reinforces the idea of the difficulty of placing herself within her own narrative, and perhaps also reflects the importance she gives to him, in relation to her, within the context of her narrative. She goes on to mention herself and then her family, seemingly seeking, at the start of the interview, to reinforce the *"very just normal* (a word she often uses) *happy, upbringing"* (P1, 15) she had within her family. She may also be speaking to a wider societal narrative of stigma, reflecting her own confusion and grappling with beliefs surrounding the reasons why her brother *"is always going to be an addict"* (P1, 24).

Throughout the interviews, many voices are present in the participants' stories, some more dominant than others. They are the voices of mothers, fathers, siblings, extended

family members, and society, and they impact the space left for the participant within their own (often silenced) narrative.

Summary

All participants' narratives place themselves as the secondary character in their experience. Due to the subject of their sibling's substance misuse actively being avoided within discussions in the family setting (or if it is spoken about, being associated with conflict) it is understandable why they struggle to articulate their experience. Viewing themselves as invisible or not a part of this seismic experience within the family system (and others within the family treating them as such), leaves participants confused about whether they are allowed to feel affected. The stigma around the subject causes secrecy and the hopelessness of the situation leaves participants feeling that speaking about it is pointless or burdensome to others. As a result, the experience is silenced and participants are left in a position where they feel there is no space for their experience, let alone their voice.

4.2.2 Telling their story: Tragedy, confusion, and disorder

Different tones were evident in the telling of participants' stories. Overall, they reflected tragedy and confusion, with the structure of the narratives often muddled chronologically and conveying contradictory ideas or feelings. The participants seem to try to reach a resolution or conclusion at the end of their narratives. Whilst some participants have shared their story (in part) previously, due to work or therapy settings (P3 and P5), and have therefore processed some elements of their experience, other participants were speaking about it for the first time. Perhaps this contributed to the extent of their ability to reflect on and acknowledge emotions felt. In the case of P4 and P5 (whose siblings no longer misuse substances), it proved easier to include aspects of resolution by the end of their narratives, than with other participants. Even in P5's story, her narrative becomes muddled in places and she remains baffled as to how or why her brother stopped using cannabis. She is also struck by the impact parts of the experience still have on her: *"I didn't realise that that was still quite so emotional for me"* (P5, 526–527). For other participants, the lack of resolution seems to reflect not wanting to *"deal with it any more"* (P1, 177), or being unable to move away from the experience, finding instead no foreseeable change or end in sight: *"We're going to have it for life basically, it's gonna stick with us for life"* (P6, 965–966). Sometimes, an unspoken plea for help feels embedded in the narrative. When participants see their narratives as a vessel through

which to pass on learning or advice, however, this seems to bring some resolution to their story, transforming their experience into an opportunity to pass on knowledge to others.

Participant one:

P1's narrative reflects that of a constant struggle. Describing it in a causal way, she states that her brother's substance misuse[3] has a *"massive impact on [her] family"* (P1, 451), seeing it as causing her father to develop an eating disorder (due to the stress) and later a *"full on breakdown"* (P1, 46). She reports her mother also had a psychological breakdown, and feels that, due to the decline of her parents' health, she *"had no choice but to take [her brother] in*" (P1, 189). Her experience reflects one of being forced into a position she did not want, as she says: *"I didn't want to deal with it anymore, it was too hard being in the middle"* (P1, 177) and *"when the parents reject them, there's only the siblings left and you often feel that burden as a sibling"* (P1, 936). Her narrative leaves her feeling confused and *"ashamed"* (P1, 384). Her narrative explores glimpses of difficult memories from the past and considers the bleak future for her brother and family. Against the backdrop of the protectiveness and love she verbalises for him: *"I think everything considered we've got an amazing relationship"* (P1, 805–806) she concludes of their story *"I hope one day he gets clean and stays clean but I don't believe he will, I believe this will just be our lives forever and eventually he'll probably kill himself and that's horrific"* (P1, 832–834). It was difficult to end the interview as P1 seemed to be searching for answers of how to fix the situation, as I turned off the recording device she opened up further.

Participant two:

P2's narrative conveys a journey of survival. Her story starts in a chronological fashion: after introducing herself, she describes her childhood and initial closeness with her brother, and the developmental factors that influenced a change in their relationship, becoming more detached from one another. It reflects a story of sibling closeness and love, which transforms into disappointment and disillusionment. She expresses anger at times, but mostly remains detached in the telling of her experience, reflected in the comment, *"it sounds horrible but there has been so little contact over the years, it's a bit like a bereavement, I think it gets easier the less contact you have"* (P2, 565–567) "*sometimes I have to go: 'oh yeah, I have got a brother'"* (P2, 569). This detachment

[3] At times participants were unclear/unsure which substance/s their siblings were taking, at which point I refer to 'substances' or 'substance use.'

could reflect the relationship between herself and her brother. With the progression of the narrative, her delivery becomes more detached and fragmented, perhaps partly due to her trying to share more and more memories with me as they start to arise. Her narrative includes many poignant memories, expressing conflicting feelings she experienced/continues to experience. Some of these memories include her brother not turning up on her wedding day, which left her feeling *"disappointment, but it was also a relief"* (P2, 690), and going to visit her parents, where she found her brother with slit wrists in their bath, *"'you selfish prick!' I said, 'if you want to kill yourself go ahead and do it,' I said, 'but don't do it in their house!'"* (P2, 482–483). Despite recounting how she carried her brother out of the bath, called the ambulance, and tried to save his life, she also recalls that "*to be honest-that was-that was my sympathy there I was just, had it sort of, up to the top and was sort of sick of it"* (P2, 484–485). Her narrative reflects a conscious distancing from her brother and the experience in order to survive it: *"I will love him as much as he is a pain in the arse, but I can't have anything to do with him..erm..*sighs* it's not to say I didn't feel anything, I've not really thought about it so much because, umm, it's only when it comes up when I think 'oh he wants to turn up, oh I can't'"* (P2, 534–537). It felt as if she had much to share about her experience and had she not had to return to work immediately would have shared more.

Participant three:

P3's narrative is a highly reflective one, full of emotional turmoil and perhaps more reflective and less fragmented than the others. This may be due to her job as a family and carers worker which causes her to be in contact with, and regularly explore other people's experience of substance misuse. She experienced having two siblings with substance misuse issues, but in introducing her narrative she says that she will focus on the relationship between her and one of her siblings, Anna. However, inevitably, the relationship with her other sister, Nikkita, is referred to throughout. The narrative charts her journey through adoption, alcohol dependency, becoming a mother-figure to her sister, and struggling to break free of the guilt of her sister's substance misuse: *"because she's got a way of making me feel"* (P3, 118). She describes reaching breaking point: *"I just can't do this anymore, it's doing my head in"* (P3, 145), and breaking contact with her sister for a time. Following this, her narrative speaks of her and her sister evolving together; her sister gaining more maturity and less dependence, and the participant becoming a family and carers worker for others in a similar position. The participant speaks from the position of many roles in her narrative: alcohol misuser, carer, sibling,

family and carers worker, jumping from past, to present, to future, and back again. Whilst she acknowledges the struggles that she still faces, despite her sister not currently engaging in substance misuse, she sees hope for herself and her sister Anna. P3's narrative reflects an in-depth consideration of her and her sisters' childhoods and how it shaped them. Her story seems to be one of purpose, wanting to pass on knowledge to others and elicit hope.

Participant four:

P4, in comparison to other participants, speaks in a matter-of-fact way about his experience. Devoid of much verbalised emotion, he takes us through the experience in a mostly chronological fashion, with few details shared about his feelings: *"I can just talk about things and just take things back out and bury it, I don't, I don't worry about it"* (P4, 665–666), only alluding briefly to the disruption the experience caused himself and his family. Perhaps this reflects his upbringing, gender, and cultural influence. Growing up in the Caribbean, he describes life as being very different, not having access to services like social services, but instead people worked as a community to help each other. Perhaps this shapes his suspicious view of psychologists, believing that they are not people who could help him or his brother, and viewing people in the UK differently: *"you know people over here, they're not normally strong, not having a go at them, they will jump off, you know"* (P4, 203-204) (referring to people committing suicide by jumping off bridges in London), and he positions me as sharing this idea, to some extent, due to having the same heritage. As a first generation born British person of Caribbean descent, I am aware of some of the perceptions of mental health within the Caribbean community, which support his view. He says: *"you have to be strong"* (P4, 201), *"people even say now that I am a hard person in the way I think and the way I look, my outlook of life, but you know being the way I am coming from, where I come from, that's how I was brought up"* (P4, 211–213), as *"a disciplined person"* (P4, 30-31), in contrast to his brother who he describes as *"not a bad person"* (P4, 405), but *"could easily be led astray"* (P4, 348). In this context, he recounts the change experienced by him and his brothers when moving from the Caribbean to England. He speaks of the easy access to drugs in the UK, and alludes to the guilt he feels for unknowingly setting his brother up with a job at a shop, which put him in contact with drug dealers: *"the sad thing about it was that I was the person who got him that job so I felt responsible"* (P4, 139). He reiterates the importance of family throughout his narrative, and focuses on the support he and his family were able to provide his brother, to encourage him to accept help and stop misusing substances. He

states that he wants to *"educate people"* (P4, 662) through his story, and seems to use the interview as a way of disseminating advice to others.

Participant five:

P5's narrative is a painful one of isolation, feeling forgotten within the family unit, and of unexpressed emotions: "*I bottled it up for a really long time, because, because, it, that's how it'd been dealt with"* (P5, 499–500), sharing that *"when you're the child that's sat upstairs on your own you kind of wish that your parents were spending more time with you"* (P5, 252–254), *"I wish I hadn't been kept out of it"* (P5, 436). It darts back and forth chronologically with fragmented or muddled memories of her experience (such as how her brother stopped taking substances). She starts her narrative by introducing her half-brother as the outsider – adopted by her father and of a different race to her and her father. She reports having to *"put the pieces together"* (P5, 139) as there was never a discussion between her and her parents about the situation, *"just all of this information that was hanging over us"* (P5, 234–235), and instead being aware of *"vagaries that I picked up"* (P5, 487), overheard when others would have conversations. Perhaps this reflects why parts of her narrative are vague and confused, particularly around discussing the shift from her brother misusing cannabis to no longer misusing drugs, being unaware of *"what the turning point was for him"* (P5, 294). It is also worth noting that she moved away from home around this time; therefore, not being in regular contact with her family. Nearer the end of her narrative, P5 talks about the shift in the relationship with her brother, building a stronger relationship with him and feeling *"like I have a brother now"* (P5, 428). She reflects that, since her brother stopped misusing cannabis, conversations with her mother (about the past) have now been able to occur. She also reports that she had to process, and is still processing, her experience, an important part of which, for her, includes allowing herself to be angry at her family.

Participant six:

P6 describes her experience as "*an emotional rollercoaster"* (P6, 876-877) and her narrative reflects this. Starting from the point when she realised one of her elder sisters, Sharon, was heavily using substances. She recounts her story, jumping backwards and forwards chronologically to place her experience. She speaks of the early differences she notices in her sister, and the change in interaction between them (the felt role reversal of younger and older sibling, due to Sharon's substance misuse), no longer seeing *"her as a role model"* (P6, 609), and says, "*I just didn't know who she was"* (P6, 255). P6 conveys

the interaction between her sister and rest of the family, sharing how the substance misuse got worse following Sharon losing her young son to suicide, and the impact this had on the family. She shares how difficult it was for her to experience Sharon behaving, acting, and looking differently due to her substance misuse, and how *"embarrassing"* (P6, 492) this was, *"resenting her, thinking, like what's she doing to us,"* (P6, 499-500) as this impacted how the family were viewed by the community. Moving between the impact it has on herself and others, sharing their perspectives. Her narrative explores a multitude of simultaneously felt, yet conflicting emotions. The participant's pivotal moment seems to occur when she comes across case papers at work revealing Sharon's substance misuse. She states that it was there *"literally in black and white"* (P6, 534). She shared that this moment destroys what was left of the fantasy she was holding onto, that her sister might not be misusing substances, recounting that, *"I don't know if it was a good thing that I saw it or whether it was a bad thing"* (P6, 551-552*). "I think I probably wanted to have that reservation, that she could be telling the truth"* (P6, 558-559) because *"it was less of a hope"* (P6, 562), simultaneously evoking feelings of anger and betrayal: *"you can't lie to me anymore*, *"I'm not going to stay taking your shit"* (P6, 553). The interview seemed to provoke many new reflections for the participant.

Summary

Following on from the previous theme, all of the participants struggled to put into words their experience, with some being more able to access their emotional experience than others. All participants presented fragmented and confused parts within their narrative as they tried to voice and make sense of their experience, moving towards a resolution. P4 and P5 seemed to reach a cleaner conclusion to their narrative (due to their siblings recovering from substance misuse), whilst, with other participants, it proved more difficult to end the interview. It seemed that all participants wanted to move towards a resolution. This led to them holding onto the hope of the situation improving in the future and looking to advice giving as being a positive side effect of their experience (P3 and P6). Alternatively, they became resigned to the hopeless nature of the situation (P1 and P2). Even when participants were able to 'create an ending' this did not take away from the disorder and tragedy conveyed in their narratives.

4.3 Q2. How do participants narrate their relationship systems?

Q3. How do they create meaning from/make sense of their experience?

4.3.1 The role of the hero: Positioning and polarisation

Throughout their narratives, participants often seemed to position themselves in a way that, to varying degrees, appeared to fit the archetypal role of 'hero'. This seemed to present itself in various guises of 'rescuer' 'carer,' 'leader,' 'the sensible one', or 'the good one' in the family. Amid their sibling's substance misuse, some of the participants describe feeling forgotten or overlooked (P1, P2 and P5) within the family. The difficulty and helplessness felt by family members seemed to inevitably leave an opening for the role of 'hero' within the family dynamic, that participants seemed to take. This may not be a role that they consciously want, but by adopting it, they are given an opportunity to fit in, to be a part of the family unit, instead of feeling pushed out. By positioning themselves in the role of 'hero', they are allowed to claim a place in the family system. The participants are given an identity and are able to gain some power within this role. Trying to simplify and make sense of the situation and gain more control of their experience, the participants seem to place others in the position of 'victim' or 'abuser', 'good person' or 'bad person'. In some cases, participants create a 'them' and 'us' dichotomy (attempting to take away power from others in their family system). They root themselves more strongly in their role of 'hero,' thus highlighting their significance to the family. In some cases, participants strongly gravitate towards the position of 'hero', choosing it; with one participant identifying with the role from childhood (P4). It willingly becomes a large part of his identity. In contrast others find themselves placed in the role (e.g. P1 & P3), with the hope of it creating an identity for them within the family structure. However, the role does not always resolve the invisibility felt by participants within the family.

P1 reflects on how her role in the family has changed:

"*umm..I'm sure I'm selfish now in some ways, but I think I was just, I was a teenager then, I think it was all about me, my world, you know, I really cared about everybody but I just think now errm you take on more of a carer role for your parents, my parents are only in*

their early 60s and they're very active and lead a, you know a fun life…[4] *and things but you do take on a carer role, you get to a point where you think.. and I think maybe I've done it because of this…otherwise it wouldn't have happened for a long time but I think, but I think, if I said that to my mum and dad they'd be like 'Oh my God you don't need to do that! Don't be ridiculous' umm but I feel like I'm trying to"* (P1, 749–761).

P1 finds herself in the 'carer role' because of the situation with her brother, implying that even though her parents are unaware of this, or do not explicitly wish to push P1 into the role of carer, she feels she needs to fill this role. There is a secrecy in what is happening, not wanting to let her parents know that she is taking on this role, as they would disapprove and tell her not to (perhaps then leaving her with no role), but also experiencing a pressure that this is the available role in the family that needs to be filled.

She further identifies herself as the responsible, 'sensible one' when she talks about the striking contrast between her and her brother:

*"I don't drink at all, I've never touched drugs..umm, I'm a massive control freak..ermm I think I've always been a little bit like that, but not quite so bad, when I was younger I used to enjoy going out to the pub, get really drunk like most 18/20 year olds do and then when this happened and got quite severe, I wouldn't drink because I wouldn't want to be out of control of myself coz I'd think: 'well what would I do, what if I went and took some drugs and didn't know what I was doing'…and then I end up like him, see I think it has had a massive impact on my life, umm I'm very, uumm, not conservative, but I..umm..I dunno, my brother calls me 'Captain Sensible' *laughs* that probably sums it up"* (P1, 527–539).

P1 describes herself as "a massive control freak" in contrast to her "out of control" brother (P1, 130). To protect her from becoming like her brother (a position already taken within the family system), and being seen as very distinct from him, she positions herself as the polar opposite, not drinking or taking any drugs and being "conservative". Her brother describes her as "Captain Sensible," denoting a hero-like status.

Meanwhile within P2's narrative, dichotomies are also evident, choosing a career as a police officer in contrast to her brother who has multiple criminal offences. She often

[4] "…" denotes points where the interviewer's response has been omitted due to it consisting of "hmm" or "mmm" and deemed irrelevant to the parts of the narrative being shared by the participant

distances herself from him, grouping him in the term ‘drug addicts’ when she talks about him and making statements such as *“drug addicts are selfish”* (P2, 399).

She takes on a ‘carer role’ within the family, allowing her father to move in, attempting to protect her parents from being exploited by her brother. In the following example, P2 tries to take care of her mother’s emotional wellbeing by reassuring her that it is not her fault that P2’s brother started taking substances, therefore the blame rests solely with him, for making “bad decisions”:

“*‘mum, but it’s not your fault..it is not your fault how Danny’s turned out’ I said, ‘you’ve got me and you’ve got Danny’, I said ‘we were brought up exactly the same’, I said, ‘so how can it be your fault?’...I said, ‘some people just make bad decisions’”* (P2, 831–-835).

By seeing her brother as ‘the bad one’, she is able to bring order to the confusing situation within her narrative, seeing things in black and white, and simply concludes that *“every family has got their black sheep”* (P2, 1265).

P2 speaks about the change in the relationship between her and her brother in adolescence, as he went on to make friends, no longer *“want[ing] to be with his geeky older sister”* (P2, 61). There is a sense of being rejected or forgotten by him, and later she speaks about feeling rejected by her family as well. One Christmas, when the family’s plans are derailed because of her brother, upon visiting her parents with her husband (Thomas) she remarks, “*‘I’ve been always put on the backburner’”* (P2, 774) *“‘the fact is, it’s easy to drop me isn’t it because an-and dad to go off because I do everything right,’ I said, ‘but no one cares about mine or Thomas’ feelings’”* (P2, 783–784). Although P2 occupies the role of ‘hero’ (she identifies with being ‘the good one’ by doing “everything right”) she feels, despite her efforts, that this is still not enough to be seen by the family.

P3 and P4 also strongly identify with the position of ‘leader’. P4 states that his family *“see me as the head brother”* (P4, 501), “*I think the head role I’ve given it up”* (P4, 281), *“I used to have the head role you know”* (P4, 281–282), and he seems to derive pride from this identity. He is afforded the choice to give up the role when he no longer needs it. By strongly identifying with the ‘carer’/‘leader’ role, it seems that P4 feels like the insider within the family unit and does not feel pushed out, perhaps feeling that having the choice to take on this role protects him from feeling the burden of it (as opposed to other participants’ experiences).

P4 recounts growing up as *"a hard person"* (P4, 213) and strong, in comparison to his brother, who he describes as easily led by others: *"the problem one"* (P4, 12) *"black sheep of the family"* (P4, 279), and the *"one that gives trouble"* (P4, 34).

P4 describes that, due to his brother's nature, he needs to guide him:

"*it's like you have a child at home, you're strong a father, you know, you think your child will get strength from you, if you're a weak person they will get the weakness"* (P4, 616–617).

In this metaphor he compares himself to a strong father (care figure), needing to be strong to help his weak brother. He continues to see himself in this powerful position, referring to his brother as "people like them," instead of grouping his brother with himself, as an 'us':

"you have to be consistent with people like them, because once you leave them and they think that you don't care, they will just break the trend of what you're trying to achieve for them" (P4, 144–146).

This contrasts with the importance P4 places on the togetherness of family in his narrative and *"grow[ing] up as a team"* (P4, 224). Positioning his brother outside of the family unit at times, he seems to find it difficult to integrate these two ideas. This perhaps reflects P4 trying to manage the conflict between stigma felt around his brother's substance misuse and wanting to defend his family. This conflict is evident when he talks about what helped the process of his brother stopping substance misuse. P4 identifies the support he received from his family, and repeatedly describes only them as being 'clean' and 'good' people like him, suggesting that his brother does not fit within this, but "has potential":

"the support from each person each-each member of the family and the cousins and the aunties - you know, because they're all clean people, you know, it's a good thing they're all clean people clean clean skin people, you know, they're not into any drug dealers you know they are not, they're working people you know they are decent people you know put it this way, ehh-you know more everyday people umm...they proper people you know because people are good and people are bad but fortunately don't have any bad bad person in our-in our family that much, you know...apart from one uncle we did have in [names a country in the Caribbean] you know but he-he passed away now, yeah umm, yeah so umm everybody have a clean slate you know, everybody put their hands and heart

into it, yeah, you know you know, they all come out because he has potential you know he wasn't a bad person, you know, he's not a bad person" (P4, 393–405).

Similarly P3 also talks about 'naturally' being the leader in the family, *"because I was always the oldest and always the most responsible"* (P3, 406). When recounting her childhood, she says:

"I always took the lead, I don't think I was bossy but I always.. I think they were quite scared of me, not sure why.. but I'm, what I call a loner anyway, so I probably more of, off doing my own thing" (P3, 419–421).

Despite identifying that she "took" the role, she also speaks about becoming *"even more of a mother figure to her"* sister, Anna, (P3, 161–162) later in life, following the death of Anna's biological mother. The role of leader turns into carer, and in her description, it seems there is a *need* for this role, and perhaps contradictorily, a lack of choice in taking up the position. She indicates a negative consequence of being the leader as also being "a loner," outside of the close relationship her sisters share: *"it was Anna and Nikkita was together a lot, so…and I was kind of on the outskirts"* (P3, 428–429). It is unclear whether P3 identified with being a bossy loner ("*I don't think I was bossy"* (P3, 419)) before feeling pushed out. It could be that one way of asserting herself or being noticed was by taking the lead.

P3 described when Nikkita became the last child to be adopted into the family, leading to a change in the relationship she had with Anna: *"that probably made me very angry..because Nikkita was, we were so close beforehand as well, yeah it probably felt like I'd been pushed out"* (P3, 439–440). This dynamic of being the outsider seems to continue even into P3 and her sisters' substance and alcohol dependency. Whilst P3 misuses alcohol, Anna and Nikkita both misuse illegal substances (cocaine and crack cocaine). Her sisters struggled for a long time with their misuse (one only having recently recovered and the other still battling), but again, P3 describes herself as having now matured, and states that she has been sober for a long time. P3 separates herself from her sisters implying that they remain in the victim role which she has managed to transition out of. *"I think I played the victim for a long time, myself, in my own addiction, I was a victim for a long time and I would never take any responsibility and quite angry...so I think I've matured finally, and can look at it, in a different way"* (P3, 290–293).

Dichotomising the two sisters, P3 describes Nikkita retrospectively as never being able to fit into the family: *"I think she was very damaged from a young age, I don't know*

whether she was able to fit in if you like" (P3, 408–409). She seems to write Nikkita off and simultaneously position Nikkita as a victim, fantasising that if Nikkita had stayed away, and was no longer a part of the family, *"I might have had a happier childhood"* (P4, 470), and that P3 and Anna would have been closer. P3 comments in the interview how surprised she is when she reveals these thoughts about Nikkita, indicating feeling bad about having them. She refers to Nikkita (due to being found abandoned at 4 years of age) as being *"missed out completely,"* (P3, 416). *"I feel like she didn't get given a chance"* (P3, 418). Despite Nikkita being the youngest, P3 describes Anna as occupying the role of *"the baby"* (P3, 416) in the family. By positioning her sisters as victims, P3 is left either abandoning them or trying to rescue them. With Nikkita, P3 states that even from childhood they were *"quite distant"* (P3, 226), rationalising that Nikkita cannot be helped (which extends to Nikkita's son who also has addiction problems, *"although we wanted to help we didn't feel we were able to"* (P3, 215–216)). She distances herself from Nikkita, stating that *"although I love her, I don't like her very much,"* (P3, 219–220) *"we're just very different"* (P3, 240).

P3 instead seeks to move closer to her other sister, Anna, "*the girl that could have done anything, gone anywhere, been anyone she wanted*" (P3, 246–247); however, it seems this can only be achieved through the role of rescuer. P3 describes their relationship as changing in Anna's mid-20s *"where she started sort of needing me more"* (P3, 244). Anna even identifies P3 as being in the 'carer role', telling the participant *"'I know I'm too needy with you um, but you've always been like my second mum'"* (P3, 252–253). However, in the role of Anna's rescuer and carer, P3 is burdened with a responsibility she cannot cope with:

"I am the oldest sister, I've always been 'the looker-after'… 'the looker after-er', um especially her, and she'd always kind of relied on me and when I say no she..but I-I have to think about it and I had to think I can't, this is not doing me any favours" (P3, 120–123).

She speaks about how she helped Anna leave her abusive boyfriend:

*"she needs people, she can't be on her own and that that includes boyfriends, she's had the worst-um the first one, I did actually get her away from in the end, I sound like this brave hero *laughs* when I talk about it, but it wasn't, it was scary, I had to get her out of there to my friend, and she was still using, so she nearly disappeared back, because she wanted the-the drugs"* (P3, 189–193).

Here, P3 suggests that she does not want the role of the "hero," that she does not identify with this position, but that she "had to" save Anna. By placing her sister in the role of the victim, the participant is forced into the position of the rescuer. In this situation, she seems to want to be rescued herself, but it is not possible. The fantasy of sounding like a brave hero is incongruent to the reality of feeling scared and not heroic. Whichever role she takes, it seems P3 can never have parity with her sisters; however, in the role of the 'hero' she can at least be acknowledged within the family system and be "needed" by Anna.

P5 also feels pushed out, describing feeling *"jealousy"* (P5, 268) because of the attention her brother received as he "*was in trouble for so much"* (P5, 49). She talks about how isolating the experience was: *"because he was the naughty child, he got a lot of attention, from mum and dad"* (P5, 250–251). She compares how she has "*always been quite considerate of other people"* (P5, 33) to her brother, who is *"really selfish and inconsiderate"* (P5, 28), and recalls thinking *"let Kevin be the naughty child"* (P5, 156) when she discovers he is misusing substances. Seeming to place herself in the role of 'good child,' despite not directly calling herself such, P5 suggests that she *"wasn't exactly a bad child"* (P5, 256) and recalls a situation when she does something *"minorly naughty"* (P5, 255). It is then that she remembers her parents explicitly naming her 'the good child':

"we tell Kevin off because he's naughty and because he does things that he's not supposed to, you don't do things that you're not supposed to, you're a very good girl" (P5, 262–264).

She also speaks about her role in the family as a carer for her father, helping him around the house and being *"his emotional support"* (P5, 274), following a back accident. She describes an incident when she attempts to protect her mother by asserting authority with Kevin: "*"what did you just say?! Apologise to mum right now!""* (P5, 95–96). Despite taking on the roles given to her of 'carer' and 'good girl' as part of her identity (which she takes with her into later life – she is currently studying counselling), she recalls continuing to feel invisible within her family unit and within her experience, concluding that:

"no matter how good I am, how much I take care of dad, he still seems to spend more time telling Kevin off, than he does actually praising me or telling me that I'm doing well" (P5, 276–278).

P6 seems to be the only sibling not caught so heavily in the role of 'hero,' perhaps due to her having many sisters with whom to share this responsibility, and being the youngest sibling. She describes at times having to look after Sharon's daughter, and how this responsibility is shared, *"it affected all of us because we had to all kind of like help out"* (P6, 784–785). It may be that, due to this, P6 feels included in the family unit and the situation. She talks about *"us as siblings"* (P6, 448) and despite the 'hero role' not being so strongly identified with, polarisation is still present – there is a strong othering of Sharon. Sharon is described as *"a rebel"* (P6, 652), *"the black sheep of the family"* (P6, 57), *"she's just different from all of us"* (P6, 632–633). In this instance, it is not the participant who feels pushed out of the family, but instead Sharon. She reports that Sharon *"says she gets treated different, but, I just think that's because of what she's done"* (P6, 379). P6 speaks about the mistrust the family have of Sharon, for instance not lending her a heater for fear they will not get it back, perhaps feeding back into Sharon feeling like an outsider.

Summary

All participants (although to a lesser extent P6) identified with a form of the 'hero' role. They often adopt, at the very least, a protective stance over their parents, to stop their siblings from taking advantage of them. Simultaneously, they also take on the role of supporting their sibling, whether voluntarily, or due to pressure felt to adopt this role. The role forces polarisation to occur in how family members are viewed and positioned in the family. The 'hero' role becomes a role that promises to bring with it more visibility and inclusion for the participant within the family unit, even though in most cases, unfortunately, this does not occur.

4.3.2 Learnt dynamics: Striving for boundaries and control

Participants often commented on the lack of boundaries experienced within the family dynamic. The substance misuse siblings were seen by participants as taking *"the absolute piss"* (P1, 684), with the family allowing the sibling to be *"focused on"* (P5, 32) and the family environment being geared towards the sibling's *"space and what [they] wanted to do"* (P5, 32). The parents were often described as victims: *"I felt sorry for mum and dad"* (P6, 503), being taken advantage of by siblings: "*'God, dad, stop being so gullible, how long is this gonna go on'"* (P2, 1129–1130), and being unable to implement boundaries. P5 recalls her mother speaking about her brother, *"I used to dread him coming over"* (P5,

211) but *"I didn't want to kick him out of the family because he's my son, I can't just get rid of him because I don't agree with his behaviour"* (P5, 215–217).

When parents are present in the narrative and their dynamic is described, a similar pattern appears: one parent trying to implement boundaries, but struggling to, and another who lacks boundaries completely. P1 describes how this manifests in her family: *"my mum is very 'oh poor Jack we need to look after him' and my dad's like 'he brings it on himself, it's his fault'..you need to shut the door and not talk to him"* (P1, 143–145). With this approach, P1 describes how both of her parents end up psychologically destroyed by her brother. Whilst P2 suggests *"my mum was the disciplinarian I would say"* (P2, 29–30) and describes her father as *"soft"* (P2, 666). She illustrates this by recalling one incident when her father convinced her mother to visit her brother in prison, because at first her mother refused. Sadly P2's mother passed away, so she has now invited her father to live on her property to protect him from being taken advantage of by her brother.

In a couple of cases, similar dynamics that played out between parents and siblings were passed on to participants and their partners (P1 and P2), when left to deal with their siblings. P2 describes the difficulty of trying to get her husband to understand that boundaries need to be implemented with her brother. She describes her husband as *"one of the softest blokes you'll ever meet,"* (P2, 541) *"and always felt sorry for my brother, and I'm always like 'don't feel sorry for him! You don't understand!'ermm to be honest what he's put everyone through"* (P2, 541–543).

Despite boundaries being identified by all participants as necessary to put in place with their siblings, few felt able to do this successfully. P3 acknowledges first-hand the difficulties of saying no to her sister, but feels it is important and so advises families and carers that *"you can start by putting boundaries in"* (P3, 492). P1 talks about struggling with this aspect currently and her parents wrongly seeing her as being able to implement boundaries easily in her role as the 'hero':

"my dad still doesn't know that Jack's coming over over the weekend for umm 10 days, but my mum does umm and, I texted her and said 'he's booked his flight, he's coming over at this time' and even then she said 'are you sure you're happy to have him? umm are you sure you're ok with it? you're so much more strict with the rules with him umm you're- you're much more stronger than we are at the moment with things..' so I think they do acknowledge that there's a reason, umm but I'm already anxious about him coming to stay..I know he'll be fine and he won't, he won't do any drugs or anything but I just

think..I'm frightened a little bit, and when he's in my house, I just, get really anxious" (P1, 761–772).

On way participants seemed to create boundaries, in an attempt to protect themselves, was by cutting off from their experience (using emotional defences such as detachment/denial). They stated:*"I have to almost become detached from it"* (P1, 426–427),*"sometimes I have to go: oh yeah, I have got a brother"* (P2, 569). Alternatively they stopped contact with their sibling. P2 and P5 said *"it sounds horrible but there has been so little contact over the years, it's a bit like a bereavement, I think it gets easier the less contact you have"* (P2, 565–567) and *"why would I stay in contact with him if he's wasting his life and he's this paranoid asshole basically"* (P5, 361–362).

In the role of 'hero', it seemed that not only did participants seek a place in the family system, but they also wished to assert authority and find a way to create boundaries in which to feel safer and more in control.

Summary

Due to boundaries often being broken, or not created at all within the family unit, (particularly in relation to the sibling and their substance misuse) all participants tried to create boundaries themselves. They would create emotional or physical boundaries in an attempt to protect themselves and loved ones. The approach (emotional, physical or a combination) varied among participants.

4.3.3 Survival guilt: Who is to blame?

Perhaps a big challenge in implementing boundaries is the guilt experienced within the family dynamic. Guilt and blame seem to play a role within the narratives, as participants and families struggle to understand how they find themselves in the situation. These feelings move around throughout the narratives, directed at different family members – from the sibling, to the parents, and to the participants themselves.

Within her discourse, P2 talks about the choices her brother makes in contrast to her. In relation to finding out her brother was smoking cannabis for the first time, she recounts: *"I was a lot more naïve than my brother I think probably because the type of friends I was keeping compared to the type of friends who he decided to keep"* (P2, 75–77), and states that *"drug addicts are selfish"* (P2, 399), describing her brother multiple times as selfish: *"I think it goes back to the selfishness, I don't think they realise the impact, to them it's always about 'I need my next fix, and I don't care who it affects'"* (P2, 613–

614). She seems to view his substance misuse as part of his nature *("he's always had that element of selfishness"* (P2, 686)) as opposed to seeing the experience as an illness.

For all participants there seems to be an eternal battle as to how much blame can be attributed to the sibling who is using substances, as there is a struggle to pull apart how much agency the sibling has in their substance misuse. However, all participants seem to conclude that their siblings have at least some agency, that it is not an uncontrollable illness.

P3 asks herself *"what the hell is wrong with us?"* (P3, 268) when considering that herself and all of her siblings have misused substances. She reflects on the influence of Nikkita on Anna's substance misuse although guilty feelings begin to emerge as she says, *"it sounds like I'm blaming her"* (P3, 469). Even when P3 distances herself from Anna, to help her to become more independent, P3 touches on feelings of guilt and responsibility for the situation: *"you feel neglecting emotionally aren't you, 'cause it's your problem"* (P3, 113–114). P4 blames himself for his brother's substance misuse, for unknowingly putting him in contact with people who took and sold drugs, when simply trying to help his brother get a job: *"the sad thing about it was that I was the person who got him that job so I felt responsible"* (P4, 139). This relates to P4's perception that he had the privilege of being born the "strong", "disciplined" one who should be able to protect his brother. P6 talks about keeping her sister's substance misuse a secret, as she felt embarrassed and ashamed within her community:

"you thinking oh, you know they're talking about your family, you know like sort of, it kind of gets your back up a bit, and then I sort of like start resenting her thinking, like what's she doing she doing to us, like d'you know what I mean, like, you know, our name's never on the road" (P6, 497–500)

and thinking that the neighbours would assume it was her parents' fault:

"*I felt sorry for my mum and dad because I was thinking 'well, I don't think they've done anything wrong bringing us' *laughs* you know, if we all, if they've done something wrong eith-either all us all of us would be like that or more of us will be like that"* (P6, 503–505).

Contrary to often verbalising that their sibling will not stop using substances until they are ready, participants, as an individual or as part of a family unit, often feel partly or fully to blame. They suggest that, if only they tried harder, their sibling would stop

misusing substances: *"we did try, as a family I would say, I don't know if we could have done more, we probably could've"* (P6, 582–583) and *"if you don't care, you know, they're not going to care within themselves"* (P4, 427).

This was particularly evident in P1's narrative. P1 speaks about patterns she notices, with her brother's substance misuse getting worse when her life gets better:

"I know deep down he wants to settle down and meet somebody and have a family and..I think sometimes, there's been a pattern to his behaviour, well not behaviour, but his addiction spiralling and..umm..my life progressing a little bit.." (P1, 199–203).

"I don't think it's a jealously thing or..umm.. necessarily…umm.. he's conscious of it..I think it's more a, he gets further and further away from what he perceives as maybe normality when he sees um what's happening in my life maybe?" (P1, 212–216).

"and it's not big profound things, it may just be that we're buying a house or you know, we have quite a normal family life, we've got a house near my husband, we've got a dog, we've both got jobs, it's all very boring and normal, it's not particularly exciting, but I think for him, he would actually quite like normal and stable" (P1, 220–224).

P1 suggests, in comparison to her brother, how many normal things she has that he does not, and feels that deep down this is also what he wants, perhaps feeling guilty that he cannot achieve these things as well. She tries to move the blame away from him, for this occurring, by saying that it is not jealousy or a conscious decision, but that she is lucky to have these things that he does not.

"this is just my belief..is that you're either an addict, or you're not but you choose how it comes out, well not choose, but say you ummm..err..happen to try drugs, I haven't so I'm not gonna become a drug addict, but.. he he is always gonna be an addict" (P1, 21–24).

In her understanding of the situation, P1 believes you are either an addict or you are not, and it will come out in some way, whether it be drugs or another addiction. She somehow escapes this fate, and therefore gets to live a "normal life", whilst her brother wants this but cannot achieve it. P1 seems to feel guilt about this and describes the situation as "difficult" when asked further questions, feeling uncomfortable about the thought and trying to move away from it, "*it could be completely not related"* (P1, 237).

P1 goes on to talk about boundaries that "no one" will implement, asserting what she thinks needs to happen and then quickly retracting it, perhaps due to feeling that this is

not something she should be suggesting. By moving back to the position of not knowing, it feels safer, and she will not have to risk making the wrong move:

"but all the while that no one is truly letting him hit rock bottom i.e. being out on the street, I don't know that he ever will but I don't think him being out on the streets is going to help the situation and I don't think any of us really know what-what to do about it" (P1, 278–281).

When giving advice to others she suggests boundaries need to be implemented, but again there is a fear of doing something wrong and "the guilt":

*"but at some point you do have to cut it off and let them sort it out, but I know that I'll never be able to do that because I just, the not knowing and the guilt and the what if, what if I do that and something happens? I just, and I think that's a stress thing and I don't think I could do that, but I would advise someone else to do that, but I can't do that *laughs nervously*"* (P1, 909–914).

There is a responsibility P1 feels she holds in protecting her brother, being lucky enough to live a "normal life" in comparison to him. There is a sense of duty that she must rescue him and not just "let them sort it out", a sense that what is happening for him is her fault.

Throughout the narratives, it seemed that if the sibling was unable to give up substances, participants believed, at least in part, that it was their or their family's fault, resulting in feelings of shame and/or guilt.

Participants seemed to feel conflicted when making judgements about other family members' actions. By naming/identifying 'incorrect choices' made by family members (which they perceived as helping to maintain or causing their sibling's substance misuse), this sometimes clashed with, and at other times complemented, the need to defend their family. It was difficult for the participants to resolve this conflict, as by grouping people within the family as 'good' or as 'victims', siblings or others were then seen as 'bad' at times, or not behaving as they should (for example, parents were not implementing effective boundaries). Difficult though it was for participants to pass judgements on other family members without feeling guilt or needing to justify their emotions, the presence of stigma made this process even more complex. During the beginning and end of narratives, participants seemed to try to protect the family, wanting to move away from being judged by outsiders (readers/society), or by me as a researcher. It seemed that participants felt more comfortable, opening up further near the end of the interview, and

then needed to protect themselves and their families again right at the end. Stigma seemed to loom over their narratives as they closed by attempting to defend their family, explaining the "closeness" of their family unit, "normal" nature of their upbringing, that the experience could happen to anyone, or that they still loved their siblings who were "not bad people".

Summary

As they attempt to understand why their sibling is using substances and behaving differently, the participants and their families turn blame towards themselves and others in their family. The participants question their actions and those of others in the family, sometimes believing that their sibling's behaviour is their fault. With this, shame develops, afraid of being judged by others within their community or in wider society. They are afraid of them or their family being blamed by others for their sibling's actions, whilst simultaneously feeling the need to protect their sibling. The protection of their sibling protects the participants from imagined future catastrophe and guilt. This catastrophe manifests (in the participants' minds) as the possibility of the sibling destroying themselves. Participants also expressed the need to protect their families from judgement, further exacerbating the occurrence of not talking about their experience and keeping it a secret, thus reinforcing theme one.

4.4 My reflections

It was interesting reading back over my own transcript following identifying key themes within the narratives of the participants. Considering my own experience of having a sibling with substance misuse issues it felt easier for me, than some participants, to place myself within my experience, but it has taken me a while to get to this point. Certainly, my training on the counselling psychology doctorate has made me think more about this and the importance of having a voice, reinforcing the necessity of my thesis.

Embarking on the analysis proved daunting, and with so much rich data to draw upon, I wanted to make sure that all of the participants' voices were heard, and were heard accurately. It was difficult to unpick the complexities of the dynamics present in the different narratives, and I feel there was so much I could have written about, with many nuances present. Ironically, this caused my analysis to perhaps feel slightly more dichotomous/exaggerated than these themes would seem in the context of the full narratives, with so much unsaid, and endless contradictions present. However, the nature of analysis is holding a magnifying glass to the narratives and focusing on specific areas

that called out to me. Discussions with colleagues, in research consultation groups, and with my supervisor, hopefully allowed me to choose pertinent areas that will allow the reader to engage with, and think further about the participants' experiences.

My family dynamics are similar to those identified in the narratives, but in my own story I feel that, within the context of my sibling's substance misuse, I have moved away from so actively engaging in the role of 'hero' and feeling that I need to fix the situation, which is how I felt at the start of my research project (perhaps because in some ways this project allows me to feel I am doing something). This is a work in progress, and it is interesting how many participants studied psychology or went into a law enforcement-related (police) or caring profession like myself. Each participant seems to be at different stages in the journey of their experience, and are trying to find ways to manage the situation that work best for them. As with my own transcript, it simply shows a snapshot of their felt experience at the time that the interview was carried out. Hearing the stories of participants, and engaging in personal therapy, has made me realise that it is okay for me to step back and not feel so guilty about being so distant with my sibling. I think that this is the way that I am able to create boundaries for myself to feel safe, protected, and in control. The process of analysis has certainly given me a greater awareness of the phenomenon, and helped me to understand myself more fully; I hope it does the same for the participants and others reading this.

4.5 Main findings

In summary, as discussed in the analysis, five main themes seemed to be evident in the data:

Theme one: Finding space – difficulty placing themselves within their own story: participants seemed to struggle identifying their narratives as their own, due to the focus on their sibling.

Theme two: Confused narrative structure – wanting a resolution: participants appeared to find it difficult to make sense of their narrative, struggling to find a conclusion or feel the experience had been resolved.

Theme three: Role of 'the hero' – developing an identity: participants seemed to find themselves as an outsider, wanting to rescue their family and find a place/sense of identity within the family, which often took the form of becoming a 'hero' type figure and created polarised positioning of family members.

Theme four: Striving for boundaries and control: participants appeared to try and create boundaries that they felt were lacking in the family system, sometimes as a way of trying to gain control over the situation in order to protect themselves or their parents.

Theme five: Survival guilt – experiencing blame, shame, and guilt: participants shared conflicting feelings, struggling to understand their siblings' substance misuse and sometimes blaming themselves or other family members for it, worrying about judgement and stigma from others.

CHAPTER 5. DISCUSSION

This study aimed to answer the research questions:

Q1. What are the narratives of the participants (including how they structure and convey their story)?

Q2. How do participants narrate their relationship systems?

Q3. How do they create meaning from/make sense of their experience?

In answer to these questions the analysis drew out five main themes. This chapter aims to connect these findings and other observations from the analysis process, to psychological theories and relevant research, thus placing the narratives in the context of available literature. This section will also discuss implications and limitations of the study, illuminating areas for future research, and making suggestions about the applications of its findings to counselling psychology and more broadly.

5.1 Discussion of research findings and literature

5.1.1 Theme one: Finding space – difficulty placing themselves within their own story

Participants seemed to struggle to place themselves as protagonists within their story, seeing their sibling, instead, as the main character. This fits with previous research, highlighting how attention of the family is focused on the sibling with substance misuse. The needs of the non-using siblings take second place (Webber, 2003), and instead the difficulties accompanying sibling substance misuse permeate their lives (Howard et al., 2010). Previous analysis/observations of non-using sibling experience suggested that they feel like onlookers (Barnard, 2005), unacknowledged (Howard et al., 2010), or like the outsider (Coleman, 1978).

It was only once participants were able to share their narrative that they realised the impact the experience had on them, helping to bring some order and meaning (Carless, 2008; Crossley, 2000a). In the interviews, this appeared difficult for siblings to do, but the study provided an opportunity to verbalise their experience and give themselves

permission to speak about it, perhaps facilitated by the therapeutic nature of the interview process (Drury, Francis & Chapman, 2007; Shamai, 2003). Participants identified many reasons behind struggling to talk about their experience. Some of the reasons shared, have appeared in previous research, which included the focus usually being on the sibling with substance misuse issues and/or other family members (e.g. parents) (Barnard, 2005; Howard et al., 2010), feeling unimportant (Tsamparli & Frrokaj, 2016) or not heard, the emotional strain of discussing the difficulties faced, worrying about burdening others with their story and not being understood, secrecy within the family and being discouraged from talking about it, feeling stigmatised (Orford et al., 2010), and shame and embarrassment (Barnard, 2005) about their experience.

In the wider literature siblings reported similar experiences, of feeling ignored at times, as parents' attention was often directed towards the sibling with difficulties. This was evident in qualitive research considering the experience of having siblings with autism (Ward, Tanner, Mandleco, Dyches & Freeborn, 2016), learning disabilities (Luijkx, van der Putten, & Vlaskamp 2016) and mental health issues (Sin, Moone, Harris, Scully & Wellman, 2012). It seems that not only is this dynamic apparent in the family home, but also in the wider social sphere. It is reflected in the literature where the non-using sibling's experience is often ignored; the sibling with substance misuse is usually the focus of research (Howard et al, 2010), and in treatment with practitioners, where siblings are not viewed as a priority (Barnard, 2005).

5.1.2 Theme two: Confused narrative structure – wanting a resolution

The confused structure of the majority of participants' narratives seemed to reflect the overwhelming nature of trying to make sense of their experience and put it into words. Following on from the previous theme, it conveyed the newness of connecting with and acknowledging this experience. As has been suggested in previous research, narrative incoherence could indicate the negative impact that having a sibling with substance misuse issues has on psychological wellbeing (Bamberg et al., 2008). Previous studies into the sibling experience have not considered the structure of the sibling narrative, so this finding may be something to investigate further.

There was a plethora of opinions and voices evident in participants' stories, often explaining how other family members viewed specific events in contrast to, or in support of their own views. Whilst initially attempting to tell their story in a linear way, narratives often became fragmented and confused, with causal issues being identified

retrospectively (e.g. sibling substance misuse leading to psychological decline in parents), and contradictory/uncertain hypotheses being used to explain sibling misuse or position family members in a certain way (e.g. one parent being weak and unable to implement boundaries). This could reflect the circularity of family dynamics and multiplicity of positions; however, it could also reflect a 'chaos narrative' (Frank, 1995).

A 'chaos narrative' is defined as having a lack of narrative order and plot. As a researcher I sometimes found it difficult to follow participants' narratives due to this. A chaos narrative is characterised as the person feeling a lack of control and simply feeling swept along in the experience, despite failed attempts to regain control (which mirrors the experience participants shared, in the content of their narratives). Sparkes (2005) describes how the chaos narrative reflects "disorder, distortion, fragmentation, threat, anguish and uncontrollability" (p.198). In contrast Waters and Fivush (2015) suggest narrative coherence (defined by the presence of theme, context, and chronology) is linked to psychological wellbeing. Research has found that the creation of a coherent and resolved narrative related to an experience is evidence that the person has integrated the event and processed it, preventing rumination from occurring (Schank, 1995). Previous research supports this, positing that narrative incoherence/chaos can indicate difficulty in emotional regulation and coping with an event, hence impacting identity and adjustment (Main, 2000).

This highlights the importance of siblings accessing support to facilitate processing and integration of the experience, to create a coherent narrative. Often by the end of the interview participants shared that they had found the process helpful, sometimes by allowing them to feel useful (as they were passing on advice/experience). It also seemed to help them to process the experience, putting them in touch with feelings they were unaware of, and helping them create a sense of resolution and a more coherent narrative.

Ochs and Capps (2001) wrote about our need to paradoxically have, what they labelled as both an 'authentic' (a more thoughtful, but less coherent, ambiguous, and contradictory narrative) and 'stable' narrative (a more coherent, linear, and structured narrative, with a clear resolution), which reconstruct past events. Based on this work, Shohet (2007) investigated narratives of clients with eating disorders, and mapped 'authentic' narratives to those 'struggling to recover' and 'stable' narratives to individuals classed as 'fully recovered'. Shohet (2007) explained that those who have 'recovered' have been able to create a stable, coherent, and linear narrative by internalising popular available narrative

scripts. In contrast, those struggling to recover seek an authentic script, questioning more deeply their experience and rejecting explanatory models, which results in having a less coherent narrative. Papathomas and Lavallee (2012) reflect on Shohet's (2007) findings, suggesting that those able to internalise a script could hold on more steadfastly to 'recovery', emphasising that a narrative, therefore, can shape our future actions. This could suggest that sibling support groups are essential to enable popular scripts to be available for siblings, and for them to develop a 'stable' and 'recovered' narrative. Murray (2003) explains how through our story telling we create an identity for ourselves. He posits that not only does the narrative tell others about our inner world, but also expresses feelings, intention and identity. The structure of our narrative is therefore important and the ability to create stable, integrated scripts and coherent narratives (through safe talking spaces) is paramount for sibling wellbeing.

5.1.3 Theme three: Role of the hero – developing an identity

Storytelling is heavily interwoven into our relationships with others, and helps to shape our identity; therefore, the stories we tell ourselves and others are important (Freedman, 2014). Most participants shared experiences of being simultaneously an insider and outsider. This reflected similar experiences to other siblings in the literature (Barnard, 2005). It created a difficult place from which to derive a sense of identity. Participants often spoke about their identity within their narratives, feeling the experience had shaped the relationship they had with substances and rules for living. One participant said that it taught them about moderation, with their sibling acting as a cautionary tale, another described themselves as "Captain Sensible", and felt that the experience made them more risk averse, anxious, and controlling.

Identity does not belong to one person but is created collectively through interactions with others (Mokros, 2003). Family narratives serve to preserve relational, ethic and social history of the family (Langellier & Peterson, 2004) and the family identity evolves through individual and collective narratives within the family. This identity exists within a wider cultural sphere, according to societal norms and expectations. Therefore, the family narrative consists of a public performance, as well as private communication. To belong, individuals must perform their role expected within the family unit to achieve the goals of the family (Goffman, 1959).

In relation to Wegscheider's (1981) basic 'survival roles', there is suggestion of the role of "the hero" or "strong" parental figure (Tsamparli & Frrokaj, 2016) being taken on by

participants, which can lead to, or be the outcome of, polarisation within family dynamics (Huberty & Huberty, 1986). Alternatively, perhaps in contrast, to the suggestion of "sabotaging siblings" (Huberty & Huberty, 1986), the dynamics are more complex than this, with participants not simply seeing their sibling as a one-dimensional character – 'the person who takes drugs'. This, in some ways suggests the opposite of Barnard's findings, where siblings did not consider themselves responsible for the user and family in the way that a parent did, leading to feelings of helplessness (Barnard, 2005). Instead, the participants' narratives seem to suggest they experience their sibling as taking up so much space within the family, that participants are left with the role of the 'hero', to gain space or be seen, and as a way of trying to resolve a situation all family members feel helpless in. However, it could be that the feelings of helplessness motivate siblings to try and adopt responsibility or this role, it is unclear. Within the narratives, the role of 'hero' seems rarely taken willingly. This could be explained by family identity theory and family systems theory, where narratives (Huisman, 2014) and roles (Rowe, 2012) are performed to uphold the family's identity and maintain a familiar dynamic/ equilibrium.

Sometimes, participants are placed in the hero role by parents, as experienced in Tsamparli and Frrokaj's (2016) study, and this often fails to provide a more integrated role in the family, that the participant hopes for, perhaps feeding back into feelings of disempowerment (Orford et al., 2010). It is interesting to note that five out of the six participants worked in the field of law enforcement or mental health (with the sixth participant having studied psychology), perhaps reflecting the need to continue the role of 'rescuer' or 'hero.' Research has suggested motivation for entering the law enforcement profession can include wanting to help others (Cumming, Cumming & Edell, 1965; Meagher & Yentes, 1986), which is also evident for mental health workers (Duffin, 2009) and therapists, who can be seen as occupying a dual role as 'the wounded healer' (Holmes, 1991).

Within the participants' narratives parents were often positioned as victims, which fits with Barnard's (2005) findings, suggesting siblings feel protective over their parents, but contrasts with Webber's (2003) and Tsamparli and Frrokaj's (2016) studies, in which the substance misusing siblings were positioned as victims. In this way, substance misusing siblings were sometimes seen as the enemy (again reflecting similar findings in Barnard's study) due to 'inevitable positioning' and polarisation in the family dynamic, in which family members take interdependent positions along the shared plot within the family (Ugazio, 2013). This results in frequent descriptions of the sibling using substances as

"the black sheep" or similar trope, whilst, at other points in the same narrative describing them as a "victim" of the substance, of early life experiences, or of their "nature."

The Theory of Coordinated Management of Meaning (Pearce & Cronen, 1980) describes actions in relation to context, practical forces, needs, and effects. It reflects how people view each other through their actions. It suggests that when family members are unaware of structural constraints governing another family member's actions (in cases such as substance misuse), it can lead them to see the member as 'mad' rather than 'bad', and they see the behaviour as being out of the conscious control of the family member (Carr, 1991). Whether the family member is seen as being in conscious control of their actions or not colours how they are viewed. In the case of substance misuse, this can lead to circular questioning by other family members in deciding what is driving the behaviour, and to understand and characterise the family member's actions (Carr, 1991). Part of the struggle for participants appears to be moving between questioning the control their sibling has over their substance misuse, and being impacted by their behaviour. They were often unsure of whether to hold onto the relationship with their sibling in the hope that things will change in the future, or to let go, mourning the loss of the relationship they previously had (replicating previous findings (Schultz & Alpaslan, 2016; Tsamparli & Frrokaj, 2016)). Thus, positioning was not static, and within participant narratives they often shifted people's roles and positions; in some narratives, participants would at times place themselves as victims; at other times, their parents and sometimes their siblings would be placed in this role.

5.1.4 Theme four: Striving for boundaries and control

When parents were positioned as victims, at least one parent was often perceived as having difficulties implementing boundaries. This reflects Tsamparli and Frrokaj's (2016) study, in which they found that siblings often blamed parents for ineffective boundary setting. Due to this, participants often felt pressure (sometimes from other family members) to implement boundaries with the sibling themselves, and struggled with this. Again, this fits with Tsamparli and Frrokaj's (2016) study, which found that siblings were often positioned as a 'strong' parental figure by others. During interviews, participants also spoke of wanting more boundaries in the family, to feel more in control and perhaps manage the uncertainty brought about by the experience. This supports previous findings that mixed feelings appear to be experienced by siblings, pervasively

the feeling of uncertainty (Orford et al., 2010). Some siblings appeared to try and implement boundaries by cutting off from either their experiences or the family member with substance misuse issues (physically and/or emotionally), and engaging in law enforcement jobs. Similarly, Schultz and Alpaslan (2016) found that siblings would avoid emotionally connecting to their experience, whilst Garney (2002) and McAlpine (2013) also identified that siblings would cut off from their substance-using siblings as a coping mechanism. Perhaps engaging in law-related work helped the participants to feel they can implement boundaries (although research suggests this is not one of the top reasons given by people when sharing why they pursued a career in law enforcement (Tarng, Hsieh & Deng, 2001)), or are able to resolve conflict (Hatteberg, 1992). Other participants felt completely disempowered and unable to change anything. This fits with dynamics observed in family systems theory and the family addiction cycle (Stanton, 1997) where the family goal may be to unconsciously maintain the addiction. Therefore, if the participant attempts to change their position or boundary in the family dynamic it is met with resistance. It also supports, and perhaps provides, a possible explanation for more general findings of coping strategies family members adopt in a substance misuse family (Orford et al., 2010)

5.1.5 Theme five: Survival guilt – experiencing blame, shame, and guilt

Participants expressed feelings of guilt and blame, which seemed to move around the family, often linked to feelings of shame. Other studies reflected similar emotions being experienced such as anger, blame, guilt, grief, and shame (Garney, 2002; Incerti et al., 2015; McAlpine, 2013; Tsamparli & Frrokaj, 2016; Webber, 2003). Most participants expressed a lot of uncertainty around 'who was to blame' for the sibling's substance misuse problems and what maintained it. Participants sometimes displayed survival guilt, feeling that, as they all had the same upbringing, they were lucky to escape having substance misuse issues, unlike their sibling. However, all participants saw their siblings as having some agency in the experience, not viewing the substance misuse as solely an illness.

There were questions around whether the problem was exacerbated by other family members' actions/inaction, or their own responses. Participants often felt the need to defend their family's actions within their narratives, and steer away from or justify negative feelings towards family members, perhaps feeling judged by the researcher or wider society, which also made it difficult for them to make sense of their own feelings

within the experience. This may have been due to social discourses which both enable and constrain group identity, meaning that participants may have been restricted in fully expressing feelings that present the family in a bad way, going against the family identity (Huisman, 2014). Galvin (2006) highlights that when speaking of difficulties within the family, individuals often focus instead on previous perseverance rather than current difficulties. Galvin suggested that in relation to talking about difficulties, people often needed to highlight the strength of the family, enabling previous issues to be overcome. This helped them to move away from what could be viewed as 'weaknesses' to 'strengths,' enabling their family identity to still fit into the perceived societal definition of a "good" family. This suggests a possible reason why the problem is so hidden, and highlights the impact of stigma felt by siblings (Barnard, 2005; Copello, Templeton & Powell, 2009). However, at times (though rare), participants could sacrifice the family identity for their individual emotional wellbeing and when this occurred it proved beneficial. One participant acknowledged that a big breakthrough for her was being able to give herself permission to accept that she was allowed to have negative feelings, such as anger, towards other family members (with anger being commonly felt by siblings in previous literature (Tsamparli & Frrokaj, 2016; Webber, 2003)).

Within the literature, communication difficulties in the family were often highlighted by siblings (Garney, 2002; Incerti et al., 2015; McAlpine, 2013; Schultz & Alpaslan, 2016; Tsamparli & Frrokaj, 2016; Webber, 2003), and similarly, in this study, participants' narratives indicated communication difficulties, particularly around the issue of the sibling's substance misuse, with it often being "the elephant in the room," being kept secret, only discussed between certain family members or not spoken about at all. Not only was this an issue among immediate family members, but also within the wider family, such as grandparents, uncles, aunts, partners, and friends. It seemed to lead to lying and secret keeping, due to issues of shame.

Sharing narratives is important within the family system, to create meaning from experiences and communicating these stories with each other helps them to make sense of their connection as a family and with others (Huisman, 2014). Therefore, it is unsurprising that when participants were able to share their experience, support from others was highlighted as being detrimental in aiding the psychological wellbeing of the participants and, whilst most relied on family and friends, one participant engaged in counselling (in relation to another family issue) and found it helpful in supporting her through her sibling's substance misuse.

5.1.6 Support

During this study, most participants said that they found the process of sharing their story in the interview highly beneficial, which supports other findings that narrative interviewing can be therapeutic (Lakeman, McAndrew, MacGabhann & Warne, 2012). Some participants voiced that they would have liked to have had access to therapy (like participants in Schultz and Alpaslan's (2010) and Webber's (2003) studies) or some type of psychological support previously, and may now go on to seek out further professional support. Though siblings were often unsure what specific external support would have been helpful at the time, they shared that it would have been useful to feel more included in the situation, having open family discussions. Most participants were unaware of support groups available for family members or where to go to look for help at the time, often not identifying that they needed help (as also noted in Barnard's work (2005)), but in retrospect, acknowledging that it could have been useful. This suggests GPs and professionals are failing to signpost or refer siblings to available support services. All participants agreed that more support was needed for siblings (reiterating similar opinions of siblings in previous studies (Incerti et al., 2015; Schultz & Alpaslan, 2010; Webber, 2003)). Participants suggested psychoeducation, counselling/professional support, being able to talk to other siblings/families in similar situations, and better communication within the family, would have been helpful.

5.2 Limitations and critique

My findings seem to generally support the existing literature and flesh out some of the nuances in experiences and complex issues at play, suggesting not only how it impacts the sibling, but also the experience within the family. Some themes appear to be replicated in previous studies, whilst others share mixed support. In some cases, this could be due to gender or age difference; for example, Barnard's study uses only younger siblings as participants (Barnard, 2005). In previous studies, participants have been selected based on certain age dyads (Barnard, 2005) or gender (Incerti et al., 2015), because variance in these areas has been identified as changing family dynamics (Huberty & Huberty, 1986).

<u>Critique of sample:</u>

In comparison to previous literature, I used a less homogenous group (as my sample included not just adolescents, students or families participating in a service group), with fewer participants, but was able to gain in-depth information about varied sibling

experiences. In an attempt to add more diverse experiences to the literature, I included experiences from a variety of participants residing in England. All participants identified as British, but not all were White British, and a male participant was included. It was interesting to note that the male participant was quite guarded during the interview, speaking the least about emotional impact, and strongly identifying with the role of 'hero'. Perhaps this reflects the dissonance between masculine 'norms' and the emotional nature of therapy (Rochlen, 2005), and acts as a further barrier for accessing help. Alternatively, this could have been due to his cultural background, which is less therapy-oriented (Baptiste Jr., Hardy & Lewis, 1997). However, as he was the only male in the study, it is difficult to hypothesise about this. The variance in participants recruited (some being younger siblings, adopted/half-siblings, others older; one participant previously struggling with alcohol misuse herself, and there being a mixture of genders) could be questioned in terms of homogeneity; however, I feel it reflects the range of different stories and circumstances experienced by siblings, providing us with a broader understanding of commonalities in the experience, despite these differences. With regards to cultural differences previous studies done in America (Garney, 2002), Australia (Incerti, Henderson-Wilson & Dunn, 2016; McAlpine, 2013), Greece (Tsamparli & Frrokaj, 2016), South Africa (Schultz & Alpaslan, 2016), and Vietnam (Webber, 2003) seem to share minor differences in sibling experience and perspective – most participants in the Webber study did not view the sibling as the 'victim' – which suggests culture may not be a big factor.

The type of substances taken by siblings of participants varied, and may have impacted issues such as stigma and changes in sibling behaviour. Some participants made reference to this in their narratives, describing cannabis as carrying less stigma than other drugs. In instances where the sibling recovered from their misuse, two siblings were taking cannabis. Perhaps substance type influenced recovery, and further research into experiences involving different types of drugs would be beneficial, as they could provide further nuances in the sibling experience.

The findings were constructed from the narratives of participants who were keen to participate in this study. It is difficult to hypothesize how the motivations and agendas of the participants might have differed and shaped their narratives, in comparison to other siblings with this experience, who chose not to participate. Inevitably this study was absent of narratives of the other family members and instead only considered narratives of siblings, therefore only representing one view in the family dynamic. This is true,

however, of individual therapy where, as practitioners, we are presented with an individual's experience. This highlights the complex nature of this work, trying to help the individual change an unhelpful dynamic which other family members are seeking to maintain (Stanton, 1997).

Critique of methodology and analysis process:

The research questions sought to explore various areas of the sibling experience. Some questions encouraged a more cognitively focused exploration, such as looking at the way siblings (re)construct and narrate their story. It has been suggested that narrative analysis can struggle to adequately access emotions (Kleres, 2010) due to its linguistic focus. However, context and meaning can help us better understand emotions within narratives (Kleres, 2010). Some of the research questions considered how the experience of the siblings interact with their relationships with others, and how this shapes their identity and meaning making, to help access and explore emotions further. The questions facilitated an opportunity to consider whether shared themes or similar ways of telling their stories were evident across participants, and what support siblings felt might be/have been helpful. The questions provided a good foundation on which to base the interview questions.

Narrative acknowledges that the interview questions asked and relationship between participant and researcher influences the narrative the participant does or does not tell (Willig, 2013). Though the semi-structured interviews provided rich, detailed accounts of participants' experiences, it is difficult to tell how this would have differed, using the same methodology with a different researcher. Narrative assumes that people are reflective and natural storytellers (Willig, 2013), but at times participants, especially the male participant, appeared to struggle with being reflective.

The sibling narratives provided a snapshot of their experience at a particular point in time (Hunter, 2007), thereby limiting the generalizability of these narratives. The selection of narratives and possible interpretations within the analysis highlight the many meanings and 'truths' (Polkinghorne, 1988) for each participant (in line with my ontological position). Although the analysis provided nuanced thematic descriptions, highlighting areas of similarity and difference, due to the vastness of the data, much of it was not able to be included. This meant that despite the analysis being embedded in the data, the information presented reflects my own biased selection (Willig, 2013).

This was the first time a narrative method was used with this client group, which provided an insight into possible sibling narrative structures and meant that the interviews were heavily participant led, allowing the experiences to be considered and analysed in a different way. Due to the time restrictions of the project, little scope was available to accumulate further interviews. It would have been beneficial to include more of the participants' narratives so that their stories could be experienced and understood in more detail by practitioners and readers. Unfortunately, the scope of this project could not accommodate for this, but may prove possible in the future. A bigger scale project, collecting more narratives, could add to the layers of understanding being built upon. Further to this, more in-depth questioning about support needs of siblings could prove beneficial in gaining more specific data to influence treatment guidance.

5.3 Further research

Following on from observations above, conducting research looking at specific sibling dyads, age brackets, and gender dyads may highlight further nuances in experiences, so, with this added knowledge, further research could be beneficial in tailoring treatment. First though, it seems important to add to the sparse knowledge base we have about the sibling experience. Larger scale projects collating more narratives, alongside large scale quantitative surveys, informed by my findings and research questions, would be beneficial. This would provide siblings a space to be heard, and create more scripts for others to draw on. Hopefully, as with the interviews in this study, it could facilitate a connection of other siblings with their story and help them to acknowledge that support is needed for the family, promoting awareness.

The sibling experience was focused on, due to the negligence of this group in service provision and research. It is perhaps most pertinent for siblings (of all the family members) to be acknowledged, due to their invisibility. However, if there is scope to interview the whole family, as has been done in previous studies (Barnard, 2005; Orford et al., 2010; Webber, 2003), it would be useful to further explore this phenomenon in the context of their individual roles, allowing families to acknowledge each other's individual experience. Only by doing this can we gain a greater understanding of how the different perspectives come together, to shed more light on substance misuse and what can be done to improve the situation for these families.

It is unclear what effect being unable to tell their stories about such a pervasive issue, has on siblings. Considering the impact of siblings on each other's development (Whiteman et al., 2011), and how this colours their identity, it appears to be an area that needs further research. Perhaps the difficulty in siblings placing themselves within their experience, or even acknowledging that it is impacting them (Barnard, 2005; Howard et al., 2010), reflects the difficulty of being able to access services. If people are unaware that these siblings need support, how will they be able to access it? If the problem is seen as an individual one and the sibling is in a state of disempowerment (Orford et al., 2010) how do they reach for help? More needs to be discovered about how support can be implemented and what would be most helpful for siblings, as access to siblings remains a problem (Barnard, 2005; Incerti, 2015; Schultz & Alpaslan, 2016; Webber, 2003). It could be that this is related to the terminology of support currently available. Often, family support groups market themselves as 'carers groups' (Copello et al., 2009), and siblings may not define themselves as 'carers'. From the narratives, it seems that there are multiple issues: first, identifying that the situation is impacting them and that support would be beneficial; second, knowing where to go for support; and third, having support available for siblings to access.

5.4 Implications for treatment and counselling psychology

The findings from my study provide a new insight into the experience of siblings, by uniquely accessing their narratives, it has enabled us to consider how these narratives are structured and the relational dynamics within the family, from the perspective of the sibling. It reflects complex dynamics and difficulties faced by siblings related to identity and communication with others, along with distressing emotions experienced. This implies interventions are needed to help siblings, but also highlights the systemic nature of the problem. Most participants suggested individual therapy, family therapy, and support groups would be beneficial for them and other family members.

This study highlights how siblings are often forgotten in the family dynamic and this is replicated in practice and research. It serves as a reminder for practitioners to consider how they might be able to reach out to this client group, not neglect them, and remember that not only are they treating the individual but the whole family system. Whilst recent research has been conducted in the field of clinical psychology, with a Faculty of Addictions being active within the BPS Division of Clinical Psychology, and a recent special edition publication of the Clinical Psychology Forum focusing on 'Addictions'

(BPS, 2016), counselling psychology seems to have a less active interest. Even within the most recent research in the field, the issue of substance misuse appears to be viewed in an individualistic way; a more recent journal article (2010) investigated motivation for change and discussed the difficulties for therapists treating 'addiction'. In the article, they identify individual treatment as being ineffective, and conclude that perhaps matching treatment interventions (non-action vs. action orientated) with motivation levels are more effective (Giovazolias & Davis, 2010). Considering the ethos of counselling psychology, this seems somewhat mismatched. Whilst the research attempts to approach the client as a unique being with idiosyncratic needs (Cooper, 2009), this approach, in contrast, seems to miss the socially- and relationally-embedded aspects of their experience (Cooper, 2009), by only considering an individualistic treatment. This study suggests a change is needed in counselling psychology practice, opening up research in this area and calling for a revolution in the way we approach the treatment of substance misuse.

This study proposes multiple ways in which treatment could be approached. On a one-to-one level, interventions by counselling psychologists could be beneficial for siblings. For individual therapy to be helpful practitioners need to be aware of possible issues faced for siblings in a substance misuse family (highlighted in this study), practitioners also need to help reduce stigma, empower the sibling to make sense of and voice their story, and consider relational patterns within the family, discussing communication strategies. The chaos narratives of participants highlight the need for us to help siblings voice, and come to understand, their experience, in order to form and understand their identity within the family system. It also urges practitioners to help siblings to do this within a therapeutic space. To enable this integration of the sibling experience to occur, practitioners should seek to connect siblings to other available scripts, either by signposting them to connect with other siblings through forums, or creating family support groups within their service, if possible. Practitioners need to be sensitive in their approach, as they should be mindful that siblings may find it particularly difficult to share their true feelings, due to stigma and their need to protect the connection between their identity and the family identity (Goffman, 1959). It may also be difficult to break the family addiction cycle (Stanton, 1997), when only one member of the family is involved in treatment, and practitioners should discuss the limited scope of this work with the client.

Another way substance misuse could be tackled, is by counselling psychologists using a holistic approach that considers and includes the whole family, whilst still highlighting and making space for the experience of each family member's role. Bamberg,

Toumbourou and Marks (2008) attempted a similar approach by using a family program which included specific parts tailored to parents and other parts to siblings. This would fit with the developing nature of counselling psychology. In areas of child and family work the field is beginning to evolve, tapping into key aspects of counselling psychology by focusing on strengths and resources, subjectivity, and socially constructed meaning in work with families (Sinitsky, 2016). There is an evidence base to support a move towards family therapy. Family therapy proved more effective than individual and group therapy in a systematic narrative review of 45 treatment trials for adolescent drug misuse (Tanner-Smith et al., 2013). Similarly, other research reviews considering alcohol and substance misuse in adults suggest family interventions are effective (Stratton et al., 2015), can help promote treatment engagement for family members with misuse issues, and aid recovery (Carr, 2014). Family interventions have also been shown to improve communication and help non-using family members engage in activities separate to the family, moving away from dependency dynamics with the person using substances (Carr, 2014; Rowe, 2012).

This study highlights that support networks are important in promoting the psychological wellbeing of siblings, and perhaps interventions targeting family communication difficulties would be beneficial, as has been highlighted in other studies (Garney, 2002; Incerti et al., 2015; McAlpine, 2013; Tsamparli & Frrokaj, 2016). This suggests that the issues of substance misuse within the family should be approached using less individual focused interventions. Narrative therapy with families has been suggested as being highly beneficial in helping family members move away from focusing on their own stories, when much can be lost, as they do not get to appreciate the narratives of other family members (Freedman, 2014). In narrative therapy, among other tools, therapists engage in 'witnessing structure' with families, allowing other members of the family to listen to and understand the story told by another family member; they are then asked to add to the telling and meaning-making – by contributing to and retelling this story, to make it richer and denser; the original member is then asked to retell their story in light of this (Freedman, 2014). The research process within this thesis seems to have replicated this idea, with participants reflecting that the process of telling their narrative was helpful for them. Hopefully, the retelling of participants' stories has added to the original narratives and will allow the participants to feel more empowered to retell their experience to others. Perhaps a structure like this could be helpful for families, allowing them to gain more insight into each other's perspectives and talk about the experience more freely.

In relation to addressing stigma, wanting to share experiences, and gain advice from others in similar situations, multi-family therapy merges family therapy and group therapy, aiming to help families and individual members feel less isolated and stigmatised (Asen & Scholz, 2010), which seems particularly pertinent for issues such as these. When used in cases of eating disorders, multi-family therapy focuses on psychoeducation, symptoms, relationship exploration (including working on communication skills), and implementation/relapse strategies for the future (Asen & Scholz, 2010). Perhaps integration with other types of effective interventions needs to be thought about (Giovazolias & Davis, 2010), such as Narcotics Anonymous or solution-focused therapy. From what we know about the interconnecting experiences and dynamics within the family system, from the narratives in this study and previous research, it seems if such an approach was implemented by counselling psychologists (fitting well with the ethos of counselling psychology) or other health professionals, it could be beneficial not just for siblings, but the whole family. It would allow the focus to be on family recovery, instead of on the person with substance misuse issues abstaining from substance use. From research conducted to date, it appears that treatment for siblings could consist of a combination of the above interventions; one-to-one interventions, family therapy and support groups. However, further work questioning siblings, and family members about the specific elements of support they feel would be beneficial, could help to further guide the development of treatment in this area.

5.5 My reflections

I found it difficult to recruit for this study, which was quite surprising to me; some responses were to advertisements, but the majority happened through snowballing. Although there is not enough data available in the UK to estimate the number of siblings impacted (Copello et al., 2009), statistics of people with substance misuse issues and affected family members are high, so I wondered why people were not coming forward. Whilst much of this was due to restrictions of time and resources, it seems also from the narratives, that part of this is that siblings do not identify the problem as affecting them, only their sibling with substance misuse issues. They are left questioning whether they are entitled to get help, feeling inside yet outside the situation. Another issue seems to be stigma – the secrecy shared and stereotypes participants were aware of in relation to substance misuse were negative. I was surprised that criminality was not spoken about more in the narratives, and the stigma of having a sibling that has broken the law by taking substances seemed more implicit. However, for those working in law enforcement, there

seemed to be an added layer of stigma, worrying about colleagues finding out or knowing about their sibling taking substances, which led to further shame, and in one case a participant was nearly denied her dream job of becoming a police officer as a result of this.

During the development of this research there were many points of reflection. Reading literature about 'sabotaging siblings' and survival roles allowed me to consider further the interconnected experience within the family. I was able to take responsibility for this experience and the dynamics adopted in my own family. At times it was difficult to explore and acknowledge the reality of these dynamics, but I was able to talk about this in therapy. Therapy helped me to feel contained when emotions were evoked within me as a result of the literature or interviews. My experience helped me to identify with the participants, but also at times tended to make me overidentify with their struggles. Getting feedback from others helped to untangle this. In one of the drafts of my analysis I included a quote from P5 twice, which a colleague commented on, and questioned its necessity. This helped me reflect that the line "when you're the child that's sat upstairs on your own, you kind of wish that your parents were spending more time with you" (P5, 252–254) resonated strongly with me. I realised that my need to highlight this quote was about my experience. It did not represent the key elements of what was shared within the narratives, in a broader sense. A pilot interview, during which a colleague asked me the questions on the interview schedule, also aided this reflective process and helped me identify my own assumptions.

Undoubtedly my experience shaped the process. I have reflected on the conscious aspects of this, in accordance to the narrative and counselling psychology ethos, evidenced in the inclusion of reflexivity throughout this thesis. The research process and the time that has passed has also impacted my views, changing them compared to what they were at the start of this project. During the interview process, the prompts I chose to ask then, would be different compared to questions I may now have asked. The questions I would have chosen now may have influenced the construction of different narratives and, as a result, different themes would have been extracted. For example, now I would have asked more specific questions around support such as, "Do you remember a specific time when you did feel supported by someone? What was that like? What was particularly helpful about what they said or did?" Or "If you could take yourself back to a difficult time during your experience, what in hindsight do you think would have helped in that moment?" I found myself identifying more with certain narratives (particularly P1 and P5's

narratives) than others, which perhaps reflects why it was easier for me to give a more in-depth sense of some people's stories than others. However, I did try to combat this by gaining a balance, and ensuring that I included extracts from the narratives, supporting my assertions directly with the words of participants. Reading through the transcript following the analysis, I noticed that some themes, compared to my transcript, seem less pertinent to my own story. I believe this suggests that I was able to be led more by the narratives than my own experiences, but I appreciate that my past shapes what I was able to see and not see. The thesis is the product of the co-construction between myself and the participants. It is one possibility of multiple interpretations that could have occurred. Areas that I have neglected to cover because I could not see them, hopefully will be observed and interpreted by readers.

Due to the subjective and co-constructive nature of the research, I am aware that the themes I have identified have been largely influenced by my own experience (Willig, 2013), and others may have developed different themes presented with the same data (or participants). Although triangulation is designed to help with reliability, I am aware that, for example, the 'hero' theme may have been interpreted as 'rescuer' or differently. Had I not read literature about "the hero" role (Huberty & Huberty, 1986; Wegscheider, 1981), I may have been influenced in a different way in the development of this theme. I felt more able to identify with adopting this role than with experiencing 'survival guilt', which is perhaps why it is a more strongly discussed theme within my write-up. It also reflects why I discussed the final theme so much in supervision, as though it felt pertinent to the analysis I was unsure if it was evident, due to the disconnect in experiencing it myself. It was important to remember, through my ontological position, that though some themes were not my truth they could be the reality for other participants.

In line with this I wondered how different participants' narratives would have been if I was not an 'insider researcher' – how, for a researcher without experience of sibling substance misuse, the co-construction of the experience might have been different and the data interpreted, creating other realities or experiences. I felt that perhaps, if I had disclosed that I was an 'insider researcher' to more participants at the outset of the interview, they would have been more open, and felt less stigma in sharing their narrative. It was difficult to get the balance right, as I felt that by sharing this information with them in the beginning it may have created an 'us' and 'them', meaning that they would have been less explicit in the description of their experience, assuming that I would fully understand it anyway. I only disclosed this information prior to the interview in two cases:

during a couple of discussions with participants in the initial stages, disclosing this information felt appropriate when asked about the motivation behind the study. These interviews did seem quite honest and open, but it is difficult to know if this was due to my disclosure. When I disclosed to one participant at the end of the interview that I had a sibling with substance misuse issues, this opened up many questions for them. It almost gave them permission to admit that they were finding it more difficult to manage than they had described in their narrative, and it felt that they desperately wanted answers. Unfortunately, I felt I had none to give; I could only share the resources currently available for them to try and access further support (Appendix 5). I related to their feelings of desperation and confusion. I often experienced that feeling of not knowing where to turn and questioning my responses when trying to deal with the situation; it normalised the experience and reinforced why my project was so important, and why these narratives need to be shared.

Hearing different people's narratives did, in some ways, provide answers to me and my own situation and open up new questions, which I reflected on in personal therapy. It made me think that had there been a support group available to share experiences with other siblings, it could have been beneficial to us all.

It has been challenging getting the balance right in this project, of expressing my own experiences and alluding to parts of my journey, whilst allowing there to be enough space to empower the participants and really let their narratives guide the work. The project has given me much to think about, sparking my own interest in family therapy and more systemic ways of working, considering how this could be beneficial for this client group and beyond in the field of counselling psychology.

Many questions still remain about how to promote awareness, and I hope that my research project can aid this process. I plan to disseminate my findings to the participants, staff, and service users of CGL (a substance misuse service that helped facilitate the recruitment process). I also hope that by publishing this study, clinicians and colleagues will be able to use this awareness when working with individuals and families affected by substance misuse. This may be by asking to contact family members (in particular, siblings) or inviting them into sessions, integrating support where possible, but also guiding them to access support available, and helping develop further support services, more specific to their needs, in the future.

5.6 Conclusion

From the narratives acquired in this study, it seems that siblings often feel forgotten about or pushed out of the family, being unable to connect with their experience, and dealing with confusing and conflicting emotions. Whilst sometimes engaging in a 'hero'-type role in the family and attempting to implement boundaries, making their experience, in some ways, distinctly different and largely unknown to other family members. The sibling is left with a lot of burden, whilst being unsure of where to look for help or even whether they are eligible for it. It is clear that each family member is greatly impacted by the substance misuse and plays a role in its maintenance cycle, which goes on to shape and affect relationships and communication between siblings, the rest of their family, and wider networks, with stigma playing a large role in this.

As practitioners, by gaining a better understanding of family dynamics, continuing to research and empower these individuals, and using more family focused treatments, perhaps this can aid the situation and help other family members realise the importance of listening to and including siblings. Families greatly influence positive outcomes in substance misuse cases (DrugScope, 2009; McIntosh & McKeganey, 2001; Palmer & Daniluk, 2007; Watson & Parke, 2011), so not only by supporting the family does it lessen the strain on individual members' psychological wellbeing, it also aids the whole family. Despite government policies now starting to recommend family support services, they are still in the early stages of implementing this, and it is not done consistently (Copello & Templeton, 2012).

The aims of this study were met through a narrative approach, allowing the narratives of siblings and their experience to be heard. The structure of these narratives were considered, which gave an insight into the impact of the experience on themselves and their family. Whilst support needs were identified, providing direction for counselling psychologists and other mental health practitioners more needs to be ascertained about this experience. It seems that, as practitioners, we need to be more actively signposting and referring individuals to support services currently available. It is important to learn more about individual roles in the family, such as that of the sibling, to gain a better understanding of voices that get lost and may need specific support. Counselling psychology lends itself well (through its ethos and holistic training) to approaches needed to consider the family system, however the area of substance misuse seems to have been overlooked in the field. Further research in the field of counselling psychology in the area

of substance misuse could use theory and training around family dynamics and identity constructs to explore in more depth how siblings could be supported to more fully integrate their experience, thus reducing their distress.

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APPENDICES

***Appendix 1*: Ethics form (including participant invitation letter, consent form and interview schedule*)**

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

BSc LEVEL 6 PROJECTS

MSc/MA DISSERTATIONS

PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY*

*Students doing a Professional Doctorate in Occupational & Organisational Psychology and PhD candidates should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to:
http://www.uel.ac.uk/gradschool/ethics/

Before completing this application students should familiarise themselves with the latest *Code of Ethics and Conduct* published by the British Psychological Society (BPS) in 2009. This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website
http://www.bps.org.uk/what-we-do/ethics-standards/ethics-standards

For BPS guidelines on Internet mediated research see
http://www.bps.org.uk/system/files/Public%20files/inf206-guidelines-for-internet-mediated-research.pdf

UEL's code of practice in research is a useful brief outline of good ethics conduct - see
http://www.uel.ac.uk/gradschool/ethics/

Note that researchers conducting research that solely involves animal observation or analysis of existing data (secondary analysis) should complete separate forms. These can also be found in the Ethics folder in the Psychology Noticeboard on Moodle.

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.
2. Type your name in the 'student's signature' section (5.1).

3. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc** (See page 2)
4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identity its content. Your supervisor will then look over your application.
5. When your application demonstrates good ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review. You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.
6. Your supervisor will let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

MANDATORY ATTACHMENTS

1. A copy of the invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original tests and questionnaire(s) and test(s) that you intend to use. Please note that copies of copyrighted (or pre-validated) questionnaires and tests do NOT need to be attached to this application. Only provide copies of questionnaires, tests and other stimuli that are original (i.e. ones you have written or made yourself). If you are using pre-validated questionnaires and tests and other copyrighted stimuli (e.g. visual material) make sure that these are suitable for the age group of your intended participants.
- Example of the kinds of interview questions you intend to ask participants.
- A copy of ethical clearance from an external organisation if you need one, and have one (e.g. the NHS, schools etc). Note that your UEL ethics application can be submitted and approved before ethical approval is obtained from another organisation (see 4.1). If you need it, but don't yet have ethical clearance from an external organisation, please let your supervisor know when you have received it.

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than 6 months. This is necessary if your research involves young people (anyone under 18 years of age) or vulnerable adults (see section 4.2 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable, as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the School of Psychology and the School will pay the cost.

  If you need to submit a DBS certificate with your ethics application but would like to keep it confidential, please email a scanned copy of the certificate directly to Dr Mark Finn (Chair of the School Research Ethics Committee) at m.finn@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 18 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is enough (even if older than 6 months) and you will not have to apply for another in order to conduct research with vulnerable populations.

1. Your details

1.1. Title of your course: (e.g. BSc Psychology; Professional Doctorate in Clinical Psychology)

Professional Doctorate in Counselling Psychology

1.2. Title of your proposed research: (This can be a working title)

Substance Misuse and the Family: Narratives of Siblings

1.3. Submission date: 21st December 2015

☐

1.4. Please tick if your application includes a copy of a DBS certificate

☐ √

1.5. Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mark Finn (Chair of the School Research Ethics Committee) (m.finn@uel.ac.uk**) for confidentiality reasons**

1.6. Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2009). See link on page 1

☐ √

2. About the research

2.1. Research question(s):

What is the experience of individuals with a sibling who has misused substances?

What is the narrative of these siblings (how do they structure their story)?

How do they create meaning from/ make sense of their experience?

How are their relationship systems? (family, friends, partners etc.)

2.2. Likely duration of the data collection from intended starting to finishing date:

7 months

Methods

2.3. Design of the research:
(Type of design, variables etc. If the research is qualitative what approach will be used?)

Qualitative research using a narrative method. Narratives will be attained from participants using semi-structured interviews.

2.4. Data Sources or Participants:
(Where is your data coming from? Include proposed number of participants, method of recruitment, specific characteristics of the sample such as age range, gender and ethnicity, whatever is relevant to your research)

Participants will be recruited via substance misuse agencies (third sector organisations), online support forums and advertisements in the London area. 8-10 adult participants (between the ages of 18-40 years old) will be recruited. These adults will have lived with a sibling who has substance misuse issues. The sibling misusing substances will have received or be receiving formal support for their issue. The participants will not be currently misusing substances.

2.5. Measures, Materials or Equipment:
(Give details about what will be used during the course of the research. For example, equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application)

Participants will take part in a semi structured interview. Please find attached a draft of the interview schedule detailing questions and possible prompts for participants. The researcher will use their own audio- recorder to record the interviews which will be downloaded onto their password-protected computer and encrypted before transcribing.

2.6. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

N/A

2.7. Outline of procedure, giving sufficient detail about what is involved in the research: (Outline the stages of the proposed research from sending out participant invitation letters and gaining consent through to what will be involved in data collection. For example, what will participants be asked to do, where, and for how long?)

Once potential participants have shown interest in the study by contacting the interviewer/researcher, the interviewer will send out participant invitation letters outlining further details about the study and asking for consent to participate. A follow up call will be made, ensuring that participants have received the invitation letters and seeking to clarify any questions participants might have. A time will be arranged to have a telephone assessment with the participant to gain basic demographic information and assess whether the participant is still feeling psychologically able to participate. Following this, the participant will be given the option to meet (possibly at a third sector centre, in a private room at the University of East London or at the participant's home), to participate in a recorded hour and a half semi-structured interview. If a third sector centre is used (such as a substance misuse service) permission and ethical approval will have been confirmed from them first.

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed.
See the BPS guidelines for reference, particularly pages 10 & 18, and other support material in the Ethics folder in the Psychology Noticeboard on Moodle.

3.1. Obtaining fully informed consent:

Participants will be informed of the nature of the research, with the aims being made clear to them. An information sheet will be provided with the details of the study and possible dissemination of the research in the future (e.g. in the form of a publication) will also be explained. Participants will be able to ask about any part of the research they are unclear about. They will be informed that they can withdraw their consent at any time during the data collection phase and that any data collected prior to the time of their withdrawal will be destroyed.

3.2. Engaging in deception, if relevant: (What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.)

Due to the nature of the study there will be no deception.

3.3. Right of withdrawal: (In this section, and in your participant invitation letter, make it clear to participants that 'withdrawal' will involve deciding not to participate in your research and the opportunity to have the data they have supplied destroyed on request. This can be up to a specified date, i.e. not after you have completed your analysis. Speak to your supervisor if necessary.)

As stated above participants will be informed that whilst they have the right to withdraw their information at any time during the stage of data collection, once the data has been analysed, then the researcher reserves the right to use anonymised data and the information can no longer be withdrawn. If data is withdrawn the researcher will destroy all information related to the participant.

3.4. Anonymity & confidentiality: (Please answer the following questions)

3.4.1. Will the data be gathered anonymously (i.e. this is where you will not know the names and contact details of your participants?. In qualitative research, data is usually not collected anonymously because you will know the names and contact details of your participants)

NO

3.4.2. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

(How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually names and contact details will be destroyed after data collection but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how and for how long? Make this clear in this section and in your participant invitation letter also.)

The names and demographics of the participants will be kept on an encrypted document on the researcher's personal computer, accessible only by the researcher, all paper data will be transferred to encrypted documents and shredded. The invitation letter will make participants aware of this and that quotations from participants may be used in the thesis and/or subsequent publications. The information included in the data and transcript will be anonymised, by using codes for each participant and anonymising the names of family members or other people and places mentioned. The participant will be informed however, that if they disclose any information that poses a risk to themselves or others the researcher will have a public duty to disclose this information to an authority body (e.g. The police). The raw data and transcripts will be kept for up to five years for publication purposes, in accordance with the Data Protection Act (1998), after which time this information will be erased.

3.5. Protection of participants:

(Are there any potential hazards to participants or any risk of accident of injury to them? What is the nature of these hazards or risks? How will the safety and well-being of participants be ensured? What contact details of an appropriate support organisation or agency will be made available to participants, particularly if the research is of a sensitive nature or potentially distressing? N.B: If you have serious concerns about the safety of a participant, or others, during the course of your research see your supervisor before breaching confidentiality.)

There will be a discussion between the researcher and participants as to where the interview should take place (in the participant's home, a private room in the University of East London or at a substance misuse support centre). Access to rooms owned by substance misuse services will have been agreed with the service, following ethical approval from the organization. Due to the sensitive nature of the study, participants will be made aware of the possible emotional distress they may face by participating in this research and consider how this could be managed, making it clear that they should only disclose information they feel comfortable disclosing. Participants will be assessed for psychologically suitability by the researcher. Thus will be done by having a discussion on the telephone prior to the interview with the participant, assessing risk, such as recent suicidal ideation, enquiring about support systems, exploring usual distress management and using their clinical judgment, to ensure that harm to participants is minimised. Participants currently misusing substances will not be recruited due to potential issues around risk and distress management. Participants will be provided contact details of crisis services (e.g. Samaritans) and information about support they can access should they feel they need to (e.g. Adfam).

3.6. Protection of the researcher:

(Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you? If interviewing participants in their homes will a third party be told of place and time and when you have left a participant's house?

For safety reasons if interviews take place at a participant's home, details will need to be taken of the participant's name, home address and time of the meeting and given to a buddy (most likely a research supervisor). The researcher will inform this buddy via phone when they enter and leave the premises. The participants will need to agree on this process before details are shared. The researcher has personal experience of living with a sibling who has substance misuse issues and therefore may experience difficulties when collecting the data. This will be managed by discussing these issues in personal therapy and with supervisors. The researcher will keep a journal reflecting on the process.

3.7. Debriefing:

(Will participants be informed about the true nature of the research if they are not told beforehand? Will participants be given time at the end of the data collection task to ask you questions or raise concerns? Will they be re-assured about what will happen to their data? It is good practice to prepare a debrief sheet for participants that will thank them for their participation, remind them about what will happen to their data, and that includes the name and contact details of an appropriate support organisation for participants to contact should they experience any distress or concern as a result of participating in your research.)

Participants will be informed via information sheets before interviews of the nature of the research and will have the opportunity to ask questions pertaining to this (as detailed previously). The process will be transparent and a debrief sheet will be provided following the interview thanking them and re-iterating the next process of how the data will be used. This sheet will also contain information of relevant support organisations they can contact, if, following the research they feel distressed or feel they need further support.

3.8. Will participants be paid? NO

If YES how much will participants be paid and in what form (e.g. cash or vouchers?) Why is payment being made and why this amount?

3.9. Other:

(Is there anything else the reviewer of this application needs to know to make a properly informed assessment?)

N/A

4. Other permissions and clearances

4.1. Is ethical clearance required from any other ethics committee? YES
(E.g. NHS REC*, Charities, Schools)

If YES please give the name and address of the organisation:

CRI,
7-8 Early Mews
Arlington Road
Camden Town
London
NW1 7HG

Has such ethical clearance been obtained yet? YES

If NO why not?
I am currently applying for ethical clearance from the organisation.

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation is acceptable if this is what you have received.

***If you need to apply to another Research Ethics Committee (e.g. NRES, HRA through IRIS) please see details on www.uel.ac.uk/gradschool/ethics/external-committees. Among other things, this site will tell you about UEL sponsorship**

PLEASE NOTE: Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committees as may be necessary. Also note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised. Speak to your supervisor if in doubt.

4.2. Will your research involve working with children or vulnerable adults?* YES

If YES have you obtained and attached a DBS certificate? YES

If your research involves young people between the ages of 16 and 18 will parental/guardian consent be obtained. N/A

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves children and young people who are younger than 18 years of age. You should speak to your supervisor

about seeking consent from parents/guardians if your participants are between the ages of 16 and 18. 'Vulnerable' adult groups includes people aged 18 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see www.uel.ac.uk/gradschool/ethics/involving-children/

SEE PAGE 3 FOR FURTHER INSTRUCTIONS ABOUT ATTACHING A DBS CERTIFICATE IF YOUR RESEARCH INVOLVES VULNERABLE PARTICIPANTS AS OUTLINED ABOVE.

4.3. Will you be collecting data overseas? NO

This includes collecting data/conducting fieldwork while you are away from the UK on holiday or visiting your home country.

* If YES in what country or countries will you be collecting data?

Please note that ALL students wanting to collect data while overseas (even when going home or away on holiday) MUST have their travel approved by the Pro-Vice Chancellor International (not the School of Psychology) BEFORE travelling overseas.

Please refer to the following link for the Approval to Travel form and the Fieldwork Risk Assessment form that should accompany an application.

http://www.uel.ac.uk/gradschool/ethics/fieldwork/

Basically, you must:

1. Complete the Approval to Travel form AND the Fieldwork Risk Assessment form (both found through the above link).
2. When completed, pass the forms to your project supervisor who will give your application to the Deputy Dean of the School of Psychology for signing.
3. The School will then forward your application to the Pro-Vice Chancellor International on your behalf. Applications must be received by the Pro-Vice Chancellor International at least **two weeks prior to travel**. Details about where to send an application can also be found through the above link.

5. Signatures

TYPED NAMES ARE ACCEPTED AS SIGNATURES

5.1. **Declaration by student**:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Avril Gabriel

Student's number: u1422721 Date: 10/03/2016

5.2. Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor's name: Dr Lisa Fellin Date: 10/03/2016

ATTACHMENTS

PARTICIPANT INVITATION LETTER

NOTES TO APPLICANTS: See pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This can be adapted for your own use and must be adapted for use with parents/guardians and children if they are to be involved in your study.

Care should be taken when drafting a participant invitation letter. It is important that your participant invitation letter fully informs potential participants about what you are asking them to do and what participation in your study will involve – what data will be collected, how, where? What will happen to the data after the study is over? Will anonymised data be used in write ups of the study, or conferences etc.? Tell participants about how you will protect their anonymity and confidentiality and about their withdrawal rights.

Make sure that what you tell potential participants in this invitation letter matches up with what you have said in the application

CONSENT FORM

NOTE TO APPLICANTS: Use the pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This should be adapted for use with parents/guardians and children.

OTHER ATTACHMENTS

NOTES TO APPLICANTS: See notes on page 2 about what other attachments you may need to include – example interview questions? A questionnaire you have written yourself? Visual stimuli? Ethical clearance from another organisation?)

SCANNED COPY OF CURRENT DBS CERTIFICATE

(If one is required. See notes on page 3)

Appendix 1.1: Participant invitation letter

Participant Invitation Letter

University of East London
Stratford Campus
Water Lane
London E15 4LZ
United Kingdom

University Research Ethics Committee
If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

The Principal Investigator(s)
Avril Gabriel
Tel: 0208 460 6384, email: avrilgabriel@ymail.com

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title
Substance Misuse and the Family: Narratives of Siblings

Project Description
To gain an insight into the experience of individuals with a sibling who misuses substances, giving a voice to their stories and considering relationships around them (family and friends). Perhaps the research will identify if/what support could be helpful for siblings impacted by sibling substance misuse. Participants will engage in an interview with the investigator exploring their life story which would last approximately 1 ½ hours. The investigator and participant would agree on a location that would be safe and convenient. Due to the sensitive nature of the research participants are encouraged to consider whether this would be an appropriate study for them to participate in, as it could cause emotional distress. Details of support and counseling services will be provided if participants feel they need further support following the study.

Confidentiality of the Data
The interview will be recorded using an audio device and encrypted to ensure confidentiality. Client details and those of mentioned individuals will not be included in the data; names will be anonymised, however quotations from participants may be used in the thesis and subsequent publications. In line with the Data Protection Act (1998) the encrypted data will be destroyed after five years.

Location
University of East London
Stratford Campus

Water Lane
London E15 4LZ
United Kingdom

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during the data collection period. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

Appendix 1.2: Consent form

UNIVERSITY OF EAST LONDON

Consent to Participate in a Programme Involving the Use of Human Participants.

Substance Misuse and the Family: Narratives of Siblings

I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study at any time during the data collection period without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)
…….

Participant's Signature
……..

Investigator's Name (BLOCK CAPITALS)
……..

Investigator's Signature
……

Date: …….

Appendix 1.3: Interview schedule

Interview schedule:

Introduce myself.

This is an independent piece of research.

Confidentiality, recording. Everyone will have an individual experience which will be anonymised.

If for any reason you want to stop during the interview or ask questions let me know.

Short questionnaire – demographics

Sent you a copy of the script but questions are flexible (mainly interested in bold questions, others are prompts)

Support leaflet- numbers and contacts.

I just want to hear your story.

-Can you tell me a little bit about your experience/yourself? (Can you give examples?)

- What do you remember about your childhood?
- Can you describe your memory of relationships with friends/ family?
- What did you think about person A/B (brother, sister, mother?)
- How did that relationship develop?

-Do you remember when your sibling first started using substances?

- How did you find out?
- What did you think about it at the time?
- How did you see your sibling at that time?
- Did you relationship with them change?
- How did you feel?
- How were your relationships with your family at the time?
- Roles in family- did they change?
- How did you make sense of it?
- Did that change over time?

- What helped you at the time?
- What was less helpful?
- What support would you have liked?

-Can you tell me about your life from that moment to the present?

- Did anything change?
- How were your relationships with friends and family?
- How were others around you?
- What did you do?
- Where did you/do you see yourself in this?

-How are things now?

- How do you feel about it?
- What is your relationship like with your sibling now?
- How is your relationship with other people in your life? (friends, family)
- How do you see the situation now?
- Has anything changed?
- What support do you need now?
- How do you envision the future?- relationship with sibling and family

-Why did you agree to participate in this study?
-Are there any questions you wished I had asked you? Any further comments?

- What would you change? Did you feel was missing?
- If you were your parents/grandparents what would you have liked/done?
- Looking back what would you have done differently?

-Any questions you have?
-What advice would you give others in your situation?
-How did you feel talking about it today?

Appendix 1.4: Research approval from CGL (formerly CRI)

From: Charlotte Holding [Charlotte.Holding@cri.org.uk]
Sent: 22 February 2016 13:51
To: Gabriel Avril (CAMDEN AND ISLINGTON NHS FOUNDATION TRUST)
Subject: RE: CRI Research Application

Hi Avril,

I'm pleased to inform you that your research application "Narratives of Siblings: Substance Misuse and the Family" was approved by CRI's research oversight group. Please contact Adam Huxley (adam.huxley@cri.org.uk), CRI's consultant psychologist, who had agreed to be your CRI sponsor, to begin your data collection. Also note that we will seek progress reports from you at various times during the course of your research project. I am attaching the progress report template for your information. I will be in touch with you at a later stage to see if you are in a position to provide an update on your research. If you have questions in relation to this please don't hesitate to contact me.

Kind regards,
Charlotte

Charlotte Holding
Research Administrator and Support Officer
07469375525

Appendix 2: Ethical Approval from Research Ethics Committee

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Lisa Fellin

REVIEWER: Fevronia Christodoulidi

STUDENT: Avril Gabriel

Title of proposed study: Narratives of Siblings: Substance Misuse and the Family

Course: Professional Doctorate in Counselling Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same

reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

Please find below some significant pointers, to discuss and agree upon with supervisor:

A. There is some confusion/lack of consistency throughout the application about *4.2: working with vulnerable adults.* Although the student states 'NO', there are numerous occasions in the application where the student describes the 'sensitive nature of the topic', that the participants will be 'psychologically assessed' prior to interview and the invitation letter clearly warns for the possibility of distress. I assume that if the student is a practitioner, they have a DBS already (?), which I believe shall be included in the Appendices, discussed with supervisor and ensure consistency on that throughout the conduct and writing up of this project.

B. It is unclear when reading the application form whether the researcher is an 'insider researcher', i.e. whether the student has had direct experience of/is personally involved with the topic themselves. If this is the case, then under *3.6 Protection of the Researcher*, there needs to be some description about measures towards self-care. If this is not applicable in this case, please ignore this comment.

C. under *4.1: ethical clearance* shall be obtained from CRI organisation and such evidence is to be provided to the research supervisor

Major amendments required *(for reviewer):*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH
☐ MEDIUM
☐ LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*: Dr. Fevronia Christodoulidi

Date: 29/12/2015

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name *(Typed name to act as signature):* Student number: Date: *(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mark Finn (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Mark Finn at m.finn@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant: Avril Gabriel

Programme of study:	Professional Doctorate In Counselling Psychology
Title of research:	Substance Misuse and the Family: Narratives of Siblings
Name of supervisor:	Lisa Fellin

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Age of participants changed from 18 -40 to 18 +	Participants around the lower range of the age spectrum may not be able to talk about the change across the life span due to not having experienced the effects over a long period of time. Allowing older people to participant would provide this.
No longer specific about interview venue and slight changes to outline of procedures.	Participants are not always able to attend interviews at home, my university or at a third sector service, preferring work venues or more convenient, yet private places. Therefore I have omitted specifying venues where interviews will take place. Slight changes to procedures as two telephone communications prior to interview is unnecessary and inconvenient for participants
Broadened advertising space- no longer advertising in London, but London and surrounding areas	To provide more scope of places in which to get in touch with participants
To send an email to participants a short time after the interview to find out if they would like to inform me of further information or add anything	After reading the narrative analysis literature more information can come up for participants following the interview, which can add to and help portray their story

Please tick	YES	NO

Is your supervisor aware of your proposed amendment(s) and agree to them?	YES	

Student's signature (please type your name): Avril Gabriel

Date: 3rd August 2016

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Mary Spiller

Date: 9th August 2016

Appendix 3: **Advertising material**

Have you experienced living with a sibling who misuses illegal substances?

Hello, I am Avril, a Counselling Psychologist in training at the University of East London. My research project explores **substance misuse and the family**, specifically **the experience of siblings**. This is a common, but under researched experience. If you have been affected by this and would like to share your story it would be great to hear from you.
If you are over 18 and would be interested in participating in a confidential interview at a convenient location to you please get in touch.

If you would like further information, you can email me on u1422721@uel.ac.uk or call me on 07757 448847. If you have not been affected but you know someone else who may be interested in participating please encourage them to contact me.

Thank you.

Appendix 4: Demographic questionnaire

Demographic Information

Name:

Age:

Gender:

Ethnicity:

Relationship to substance misuse sibling:

Current age of sibling:

Approximate age of participant when sibling started to misuse:

Approximate age of sibling when they started to misuse:

Approximate length of time living with sibling:

Substance taken by sibling:

Participant's current substance use:

Support received by sibling from services/services accessed:

How many other siblings in family:

Family set up:

Appendix 5: Debrief information given to participants

Thank you for participating in this research study. The recording will now be transcribed and analysed, all information used will be anonymised. If you feel you would like further support please contact the services below:

Addaction
http://www.addaction.org.uk/help-and-support/friends-and-family
One of the UK's leading and largest specialist drug, alcohol and mental health treatment charities.

AdFam
http://www.adfam.org.uk/families
A national charity working to improve life for families affected by drugs and alcohol. Telephone: 020 7553 7640. Local support groups and information for families.

Change, grow, live (previously CRI)
http://www.changegrowlive.org/about-us
A social care and health charity provides support for those impacted by drugs and alcohol.
Visit website to find details of your local service.

DrugFam
http://www.drugfam.co.uk/
Provide telephone and email support. Helpline: 0300 888 3853 (7 days a week 9am – 9pm)
Email: office@drugfam.co.uk

FRANK
http://www.talktofrank.com/
Confidential advice about drugs. Helpline: 0300 123 6600 (7 days a week, 24 hours).

MIND
www.mind.org.uk
Mental health charity: 0300 123 3393

National Treatment Agency for Substance Misuse
http://www.nta.nhs.uk/who-service.aspx
Special Health Authority, established by the UK government to increase the availability, capacity and effectiveness of ***drug*** treatment in England.

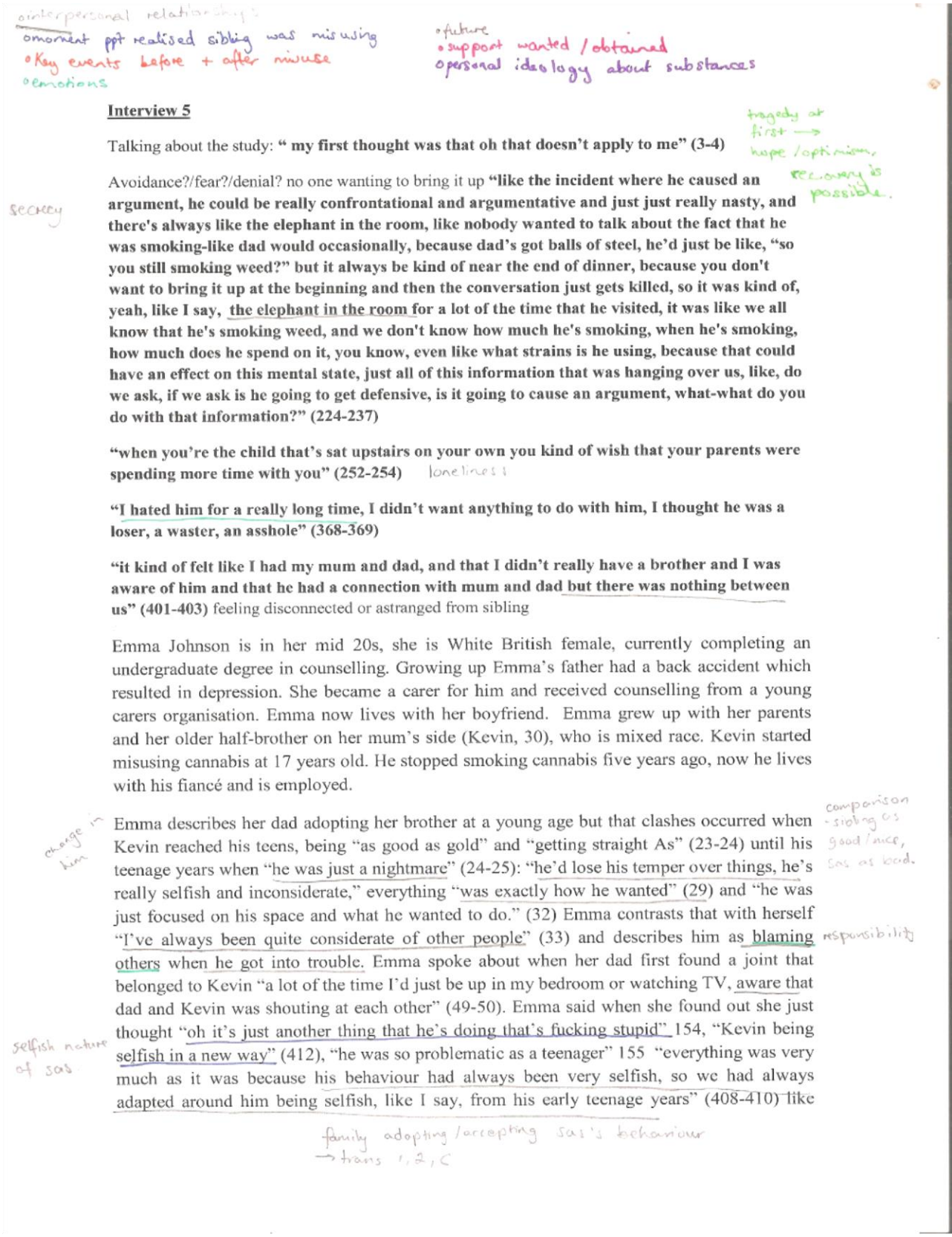
NHS Direct & NHS Information
http://www.nhs.uk/Livewell/drugs/Pages/Drugshome.aspx
NHS non-emergency number, speak to a highly trained adviser, supported by healthcare professionals. Telephone: 111 111

NHS IAPT
Access to talking therapies: http://www.iapt.nhs.uk/

Samaritans
http://www.samaritans.org/
Telephone support. Helpline: 116 123 (UK) (free to call, 7 days a week, 24 hours)

Victim Support
https://www.victimsupport.org.uk/
Support for anyone affected by crime: 0845 303 0900

Appendix 6: **Creating Themes** -Sample of transcript summary



interpersonal relationships
moment ppt realised sibling was misusing
•Key events before + after misuse
•emotions

•future
•support wanted / obtained
personal ideology about substances

Interview 5

tragedy at first → hope / optimism, recovery is possible.

Talking about the study: **" my first thought was that oh that doesn't apply to me" (3-4)**

secrecy

Avoidance?/fear?/denial? no one wanting to bring it up **"like the incident where he caused an argument, he could be really confrontational and argumentative and just just really nasty, and there's always like the elephant in the room, like nobody wanted to talk about the fact that he was smoking-like dad would occasionally, because dad's got balls of steel, he'd just be like, "so you still smoking weed?" but it always be kind of near the end of dinner, because you don't want to bring it up at the beginning and then the conversation just gets killed, so it was kind of, yeah, like I say, the elephant in the room for a lot of the time that he visited, it was like we all know that he's smoking weed, and we don't know how much he's smoking, when he's smoking, how much does he spend on it, you know, even like what strains is he using, because that could have an effect on this mental state, just all of this information that was hanging over us, like, do we ask, if we ask is he going to get defensive, is it going to cause an argument, what-what do you do with that information?" (224-237)**

"when you're the child that's sat upstairs on your own you kind of wish that your parents were spending more time with you" (252-254) loneliness

"I hated him for a really long time, I didn't want anything to do with him, I thought he was a loser, a waster, an asshole" (368-369)

"it kind of felt like I had my mum and dad, and that I didn't really have a brother and I was aware of him and that he had a connection with mum and dad but there was nothing between us" (401-403) feeling disconnected or astranged from sibling

Emma Johnson is in her mid 20s, she is White British female, currently completing an undergraduate degree in counselling. Growing up Emma's father had a back accident which resulted in depression. She became a carer for him and received counselling from a young carers organisation. Emma now lives with her boyfriend. Emma grew up with her parents and her older half-brother on her mum's side (Kevin, 30), who is mixed race. Kevin started misusing cannabis at 17 years old. He stopped smoking cannabis five years ago, now he lives with his fiancé and is employed.

change in him

comparison - sibling as good / nice, Sas as bad.

Emma describes her dad adopting her brother at a young age but that clashes occurred when Kevin reached his teens, being "as good as gold" and "getting straight As" (23-24) until his teenage years when "he was just a nightmare" (24-25): "he'd lose his temper over things, he's really selfish and inconsiderate," everything "was exactly how he wanted" (29) and "he was just focused on his space and what he wanted to do." (32) Emma contrasts that with herself "I've always been quite considerate of other people" (33) and describes him as blaming others when he got into trouble. Emma spoke about when her dad first found a joint that belonged to Kevin "a lot of the time I'd just be up in my bedroom or watching TV, aware that dad and Kevin was shouting at each other" (49-50). Emma said when she found out she just thought "oh it's just another thing that he's doing that's fucking stupid" 154, "Kevin being selfish in a new way" (412), "he was so problematic as a teenager" 155 "everything was very much as it was because his behaviour had always been very selfish, so we had always adapted around him being selfish, like I say, from his early teenage years" (408-410) like

responsibility

selfish nature of sas

family adopting / accepting Sas's behaviour
→ trans 1, 2, 5

trans 1&2- accepting treatment/behaviour from sibling and Emma thought "let Kevin be the naughty child, let him get on with making a mess of his life" (156-157) saw it as part of his identity or personality? But felt that the weed acted as "another brick in the wall between us that kind of stopped us from having anything in common" (189-190). However later she talks about it connecting them slightly when she asked her brother to get some weed for her then boyfriend, even at that point the relationship between Emma and Kevin "was still a bit strained" (199). It was not until after the misuse stopped "that we were really able to have a decent relationship" (200-201) and a "proper conversation" (202). She also suggests changes in their relationship due to him transitioning into adulthood aswell "so the dynamic had kind of changed naturally" (415) even after he stopped misusing she said "the dynamics of the family that's only changed because of growing up an getting on with life, as opposed to anything to do with him specifically" (431-432)contradictory?.

Emma described "disappointment" (248) at his behaviour and "jealousy" (250), "jealousy of the attention" (268), "he was the naughty child, he got a lot of attention from mum and dad because of being naughty" (250-251) "when you're the child that's sat upstairs on your own you kind of wish that your parents were spending more time with you" (252-254), her identity as 'good child', when she expressed her frustrations about this to her father following being told off for doing something "minorly naughty" he said "because he's naughty [Kevin]" and "does things he's not supposed to" (263), "you're a very good girl and you know we're upset that you did something that was really unusual for you" (264-265) roles and expectations within family of different siblings- identities, took caring role in family:, also helped her father around the house and was part of young carer's organisation as a result. also can be a burden- developing certain core beliefs?" I was his [her father's] emotional support (274) "and it's like no matter how good I am, how much I take care of dad, he still seems to spend more time telling Kevin off, than he does actually praising me or telling me that I'm doing well" (277-279), describes having counselling from young carer's organisation being a big help in this respect in providing counselling as being a teenager at the time she felt she couldn't talk to friends about "a brother who's a druggy" (281) and at the time was also being bullied at school for being overweight (social impact and isolation).

Like other participants Emma was unaware of when she first became aware "I just gradually sort of put the pieces together" (139-140) and that she heard snippets of conversations between her parents but knew about it before her dad did. Emma talks about how he would try and cover it up and "his bedroom always smelled of like really strong deodorant" (62) but that "he wasn't exactly subtle about it, he's not the cleverest guy" (64). She describes that "he was obviously punished somehow" when her parents found out but that he was also dating someone who moved in with them briefly who also smoked weed. However Emma said there "was never an explicit conversation about 'your brother's doing drugs'" (143-144). "I don't recall ever, whilst he was using, talking to mum and dad about what was going on, it was all kind of overheard conversation and and snatches that I picked up here and there" being insider yet outsider, like a detective

Emma describes the substance misuse having an impact on her parents "it stressed dad out maybe more than he let on" (163) but that her mum was "working a lot" so they "didn't really see a lot of mum" (167-168) as dad had a bad back accident so could only do voluntary work, "I don't really know how mum dealt with it" (172-173). A long time later once he had

stopped misusing her mother said "you know it pains me to admit it but I dreaded him coming over as well, I actually dreaded seeing my son because I didn't know how it was going to be, um but I didn't want to kick him out of the family because he's my son, I can't just get rid of him because I don't agree with his behaviour." (213-217) shared unspoken feelings in the family and contradictory feelings around role as family member and how you should be/ values/expectations as that role in the family, feelings of stuckness.

Emma's views on cannabis were quite transparent " cannabis isn't exactly, you know, it's not a hard-core drug" (148-149), "they just sort of hoped he'd grow out of it" (her parents), it took him 8 years. Emma said she believes "recreational use isn't necessarily a bad thing" (177-178) but " the way that he was using when it was problematic was a problem, it was an addiction, he had to have it and if her didn't have it then he suffered mentally and physically for it, so yeah, I think, I learned more, as I got older" (181-184). Emma said that seeing her brother's struggle with weed taking felt it normalised it in the end for her, "I think for a long time it made me less likely to want to do it" (567) but then she became curious, her dad was also an alcoholic until she was 10 and helped "reinforcing that message for me that 'don't really do anything to excess because *it's a bad idea*" (596-597)impact on her behaviour/values?

Emma spoke about the impact she saw it having on Kevin's life "he didn't want to get a job or do anything with his life," (71) he got "more and more skinny because he wasn't feeding himself" (73) and didn't have any money which was being spent on weed and he go "more and more aggressive and abusive" (74), when he started using more "he was getting paranoid and thinking that people were out to get him" (115-116). Emma talks about an incident when he was disrespectful to her parents "I can tell mum and dad are a bit, like, taken aback" (83) and so she tries to step into the parent role by telling him off "but it escalated and he ended up shouting at me" (87), saying "you're just shitty because you didn't pass your driving test" (88) with the argument then being directed to her (like trans. 6) and her trying to assert authority further, defending/protecting her mother: "I had pulled him up on being rude to mum, in front of the guests" (99-100) "I was just so pissed off with him" (102), and then she overheard Kevin saying that she was not her real sister "that was the worst of what happened when he was using" (107).emotional pain caused., she spoke about living away from home and not staying in contact "why would I stay in contact with him if he's wasting his life and he's this kind of paranoid asshole basically" (361-362), "but you know we're still a family" (113)

"I don't know what the turning point was for him" (294)- related to becoming very health conscious, getting into spiritualism and believing he was able to de-calcify his pineal gland to dream and think more effectively (she hastens to add there is no scientific evidence to support this) and found it bizarre. After the substance misuse: "the past four years I think he stopped using for a while and now he's using casually" (124-125) "but now he's got a job he's actually doing something with his life" (125-126), Emma describes how his new girlfriend is a positive influence on him and "we get on a lot and can actually have conversations" (129-130)similar to trans. 6-there has been a change in him. "before he was just too paranoid and stressed" (131-132), was in relationships with people with mental health issues, after "he was

Appendix 7: **Creating Themes** -Sample of table of themes and sub-themes

Themes

Interview 5: “talk to the family, ask questions, don't let them shut you out just because they don't think that you're involved in it, you’re involved whether they think you are or not, so so speak up and find out and ...and you know …don't let yourself get shut out of that situation because it affects the whole family. It's not just...the immediate people involved.” (518-522)
The tragedy turned to hope and optimism, however confusion as to how recovery was reached
Tone- matter of fact, teacher

Insider/outsider- feeling forgotten and isolated

isolated- "sat upstairs on your own" wishing "your parents would spend more time with you"
couldn't talk to friends about "a brother who's a druggy"- stigma
"I gradually put the pieces together"- realised brother's misuse before dad
"never an explicit conversation" about it, "caught snatches here and there" it was like "the elephant in the room"- parents were secretive
"it didn't have a huge impact on me at the time anyway"- contradictory to experience shared? feeling inside/outside?
"I do wish I'd been involved in some way"
Feeling jealous "jealousy of the attention" from parents- no matter how good she was Kevin got more attention- never good enough
"I felt like my family didn't really give me the time for me"
" I bottled it up for a really long time"- denial? Detachment?

Them vs us

feeling she didn't have a brother "there was nothing between us"
"he was just a nightmare"
"he'd lose his temper "
selfish nature" exactly how he wanted" "just focused on his space" vs "I've always been quite considerate

"he got into a lot of trouble"
Drug use seen as another behaviour
"it's just Kevin being selfish in a new way"
Distancing
"just another brick in the wall between us"
Identity/family roles
I thought "let Kevin be the naughty child" vs her being told by parents she was "the good child"
mother- " I didn't want to kick him out of the family because he's my son, I can't get rid of him because I don't agree with his behaviour"
splits in family- extended family not seeing it as a problem and favouring Kevin vs dad's side favouring her

Changes weed was perceived by her to be making on him
"he didn't want to do anything with his life"
"more and more skinny where he wasn't feeding himself"
"getting paranoid"
"aggressive and abusive"
"he was a completely different man"
"it was so awkward, you never knew what kind of mental state he was going to be in"

Sibling putting responsibility on others
when he got into trouble he would blame others
tried to assert self to protect parents “it escalated and he shouted at me…you're just shitty because"
his girlfriend is a positive influence

Family being accepting of his behaviour but ppt seeing this as unfair
"we had always adapted around him"
"they hoped he'd grow out of it"

mixed feelings towards sibling- confused how to feel

Disappointment in brother- "why would I want to stay in contact if he's wasting his life"
Hatred of brother
"he didn't want to get a job or do anything with life"
feeling anger "he's this kind of paranoid asshole basically... but you know we're still family" " I was just so pissed off with him"
reached 'breaking point'
being hurt emotionally by sibling, being told by him that she is not his real sister "that was the worst of it"
counselling helped her to realise it was OK to have angry feelings towards family
detaching to cope
""oh it's just Kevin doing something stupid" and that's how I've rationalised it so I don't have to look too deep at how emotional it was"

Influenced own views on drugs
"it's not a hard-core drug"
"recreational use isn't necessarily a bad thing"
"the way he was using it was problematic, it was an addiction, he had to have it and if he didn't have it he suffered mentally and physically"
"I think for a long time it made me less likely to want to do it"
dad's alcoholism: "reinforcing that message for me that 'don't really do anything to excess, because it's a bad idea!'

Recovery- leading to communication and positive change- idealised?
it was not until after misuse that "we were really able to have a decent relationship…and a proper conversation"
after recovery mum said she "dreaded him coming round" due to his unpredictability and behaviour
" he's got a job and actually doing something with his life"
"we get on a lot and can actually have conversations"
" there wasn't this stress and this anger"
" I feel like have a brother now"
"I love him to bits now"
"he got better of his own accord"

Support- being unsure of what self/family needed

counselling was helpful " just a space that was one hundred percent for me…with somebody who didn’t really know my family, didn't know my friends"

support/ psycho-ed for parents? Not sure if they spoke to friends or how they felt as they didn't talk to her about i.e.

did interview to "give some people a bit of hope that it could happen to them too"