The role of alcohol as men desist from physical intimate partner violence

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Title: The role of alcohol as men desist from physical intimate partner violence

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Abstract

Introduction and Aims

Although researchers have examined the relationship between alcohol and perpetration of intimate partner violence (IPV), little research has examined the role of alcohol within the process of desistance from IPV, which was the aim of this study.

Design and Methods

A mixed methods approach was taken as both psychometric test and interview data were analysed. Scores on the Millon Clinical Multiaxial Inventory-III (MCMI-III) alcohol dependency subscale of 37 men deemed to have desisted from IPV, 50 deemed to be persisting with IPV, and 49 non-violent controls were compared. In addition data about alcohol use from interviews with 13 desisters, 9 persisters, 9 IPV intervention facilitators and 7 female survivors were analysed using thematic analysis to understand the role of alcohol in IPV desistance and persistence.

Results

No differences were found between the groups' self-reported alcohol dependency based on their MCMI-III scores. However, analysis of the interview data revealed that compared to persisters, desisters reported having changed their attitudes towards alcohol and their consumption of it in order to facilitate their cessation of violence.

Discussion and Conclusions

Static measures of alcohol dependency need to be used with caution if looking to identify progress with desistance from IPV. For individuals for who alcohol played a role in their IPV, changing attitudes and their use of alcohol was described as being important in the process of desistance. Self-reported attitudes and alcohol use could therefore be used to identify men who are making progress in the process of desistance from IPV.

Keywords: Intimate partner violence; Alcohol dependency; Desistance narratives

Introduction

Studies have shown that between 50 to 60% of male patients completing treatment for substance abuse had committed at least one act of physical intimate partner violence (IPV) in the past year [1-3]. In addition substance abuse issues are overrepresented in males who attend IPV treatment programmes [4-6], with one study [5] revealing that half [53%] of attendees had an alcohol use disorder. The association between alcohol and IPV is therefore strong, with heavy drinkers and binge drinkers at increased risk for IPV perpetration [7-9].

Debate remains regarding whether alcohol has a direct cause-and-effect relationship with IPV or indirect association [10]. Some theorise that alcohol use has an indirect effect, through its detrimental effect on relationships, which then may promote conflict in relationships and finally aggression [11]. Others argue that alcohol has an independent (or direct) causal effect on IPV after controlling for variables associated with both substance use and IPV [8] and it has been demonstrated that IPV perpetration is more likely to occur on days when alcohol is consumed, compared to days when it is not [12,13]. In the Proximal Effects Model a causal relationship between alcohol and IPV is proposed, based on the pharmacological effects of alcohol on cognitive processing [14], or misjudged social cues [15]. Some have suggested that alcohol is simply used an "excuse" for aggression [16,17]. Certainly, it has been found that there is a temporal association between substance use and IPV perpetration in that alcohol use often precedes IPV [18] and occurs temporally close in time to IPV [12,19].

Although there has been extensive research examining the relationship between alcohol use and ongoing (persistent) use of IPV, little research has examined the role of alcohol within the process of IPV desistance. Studies have shown that IPV perpetration is reduced following treatment for alcohol misuse [20], which suggests that for some, limiting alcohol consumption may play a role in the process of desistance. The relationship between alcohol

used and desistance has hitherto not been examined; hence, the aim of the current study was to explore this using a mixed methods approach.

First, men who were still using physical IPV (persisters) and men in the early stages of the process of desistance (desisters) were compared to a control group of non-violent men on an alcohol dependency scale (Millon Clinical Multiaxial Inventory III; MCMI-III [21]**)**. Second, a more detailed account of the role of alcohol within the process of desistance was examined through the narratives provided by male IPV persisters and desisters, treatment facilitators and IPV survivors. Desisters' narratives are of interest as their accounts of the role of alcohol are embedded within a 'story' of IPV cessation. However, persisters' narratives reveal alternative stories and offer a different viewpoint. How this process was understood by other parties involved with these men, namely IPV survivors and treatment facilitators, was also included to establish the extent that these varied perspectives converge to identify common attributes of the relevance of alcohol to the desistance process.

Method

This study used a mixed methods approach to examine the role that alcohol played in the process of desistance. The data used initially formed part of a larger scale study that examined the process of desistance from IPV more broadly (see [22,23]). However for the purpose of this study that data was specifically reanalysed focusing only on the measure of alcohol dependency and participants' narratives regarding the role and influence of alcohol in relation to IPV desistance and persistence.

Participants

Men were recruited from community-based self-referred voluntary IPV programmes, probation-based mandatory IPV programmes and the general community. They were classified based on their use of physical violence in their lifetime and the past year using

the physical assault subscale of The Revised Conflict Tactic Scale, (CTS2 [24]) where participants are asked to report whether they have used different forms of physical violence (e.g., 'slapped my partner'; 'kicked my partner'; 'beat my partner up') in the past year, or their lifetime. Desisters[1] (*n*=37*)* were classified if they reported use of physical violence in their lifetime but not in the past year; persisters (*n*=50*)* if they reported use of physical violence in their lifetime and in the last year; and controls (*n*=49*)*, if they reported that they had never used physical violence. Of these, 13 persisters and 9 desisters agreed to participate in interviews about the use IPV and the processes of desistance, along with 7 female IPV survivors and 5 female and 4 male treatment facilitators. Table 1 provides an overview of the sample characteristics.

[Table 1 about here]

Four intervention providers for IPV offenders agreed to facilitate recruitment. No inclusion/exclusion criteria (e.g., co-occurring drug use, and/or other axis I psychiatric disorders) was specified by the research team. However, all offenders were assessed by their treatment providers for intervention-suitability, so those diagnosed with psychiatric disorders and severe drug dependency, were excluded from the interventions.

Measures

The CTS2 [24] is a self-report inventory used to assess how individuals resolve relationship conflicts in intimate relationships. It consists of 78 items represented by a five-factor model: negotiation, psychological aggression; physical assault; sexual coercion; and, injury. The 12 physical assault items were used to classify men as persisters, desisters or controls. High internal consistency, α=.88, was demonstrated.

[1] It is acknowledge that while a year violence free is clinically significant [49], this represents the first stages of desistance or primary desistance.

The MCMI-III [21] is a 175 item self-report inventory used to assess personality disorders, comprising: 11 Clinical Personality Pattern scales; 3 Severe Personality scales, 7 Clinical Syndromes scales, and 3 Severe Syndromes scales. These are interpreted using base-rate (BR) transformation scores. A BR>74 reflects the presence of a clinically significant trait or presence of a syndrome; BR>84 reflects the presence of a disorder or prominence of a particular syndrome [25]**,** which is indicative that the trait and symptoms are at the diagnostic level [26]. The alcohol dependency scale (Clinical Syndrome) was used for the current research [α=.87]. This scale has 15-items that use direct ('I have an alcohol problem that has made difficulties for me and my family') and indirect ('I have done a number of stupid things on impulse that ended up causing me great trouble') items to detect alcohol misuse and dependency. Raw scores are converted to BR scores, which can be used to determine presence of a syndrome (BR>74) or indication of trait at diagnostic level (BR>84).

Procedure

Following ethical clearance from the University's Research Ethics Committee and, the National Offender Management Service (NOMS), IPV offenders were recruited from community programmes to which men referred themselves or probation programmes to which men were mandated to attend. Programmes facilitators asked for volunteers, from those waiting for, currently attending or who had completed treatment. Controls were recruited through snowballing via social media and the Internet. All participants were asked to complete the CTS2 and MCMI-III. All participants were asked at the point of initial recruitment if they would be interviewed. Group facilitators who delivered the programmes were asked via email if they would participate in interviews and female partners of IPV offenders (survivors) were recruited via support workers). One-to-one interviews were conducted in private rooms using semi-structured schedules developed for the study. The

basic structure of the interviews for the IPV men included background information and details of the use of violence within relationships and the process of change. These questions were tailored depending on whether the man was a desister or persister. The survivors and facilitators were asked about their backgrounds regarding either working with offenders, or their experiences as victims of IPV and their views on the process of change in perpetrators.

Data Analysis

Since BR scores are not normally distributed and are nominal, non-parametric tests (Kruschal-Wallis *H*, post hoc Mann-Whitney *U*, and Chi-Square) were used to analyse the MCMI-III data. Thematic analysis (TA [27]) was used to analyse the interview data relating to alcohol. TA is a flexible approach that can be applied across a range of theoretical and epistemological approaches and allows the researcher to develop independent themes and associated sub-themes. Data analysis followed the four conventions for TA as proposed by Braun and Clarke [27]: (i) familiarisation with the data examining for patterns and themes; (ii) generating initial codes according to content and meaning; (iii) searching for themes by grouping initial codes in to broader themes and subthemes; and, (iv) reviewing themes to ensure they were coherent and captured the essence of the data.

Results

Quantitative analysis

As presented in Table 2, a Kruskal-Wallis analysis revealed a significant group difference for alcohol dependency scores. Pairwise comparisons with Bonferroni adjusted *p* values showed statistically significant differences between controls and desisters and controls and

persisters, but not between desisters and persisters. Jonckheere's test revealed a significant trend in the data with scores increasing from the controls to the desisters and then persisters, (J = 4,747, z = 6.78, p > .01, r =.58).

[Table 2 about here]

Chi-square and post-hoc analyses were undertaken to examine percentages of clinically relevant scores (i.e. BR>74), and percentages of scores that indicate presence of a disorder (i.e., BR>84) for alcohol dependency across groups and results are presented in Table 3.

[Table 3 about here]

The findings followed the same pattern for clinically relevant scores and presence of a disorder. Significant associations were found between group and both percentages of clinically relevant scores and percentages of scores that indicate presence of a disorder. Likewise, post hoc analyses revealed statistically significant differences between controls and desisters and controls and persisters; but not between desisters and persisters for both clinically relevant scores and presence of a disorder on alcohol dependency scale.

Qualitative Analysis

Data were arranged in two overarching themes that represented data at the highest level of abstraction, and first-level themes that were less abstract and more concrete representations of the participants' narratives [27]. These themes are presented in Figure 1.

(Figure 1 here)

Overarching Theme: Persistence narrative, 'When I am drunk, I use violence'

Alcohol was perceived and argued by all the participants as being a contributory factor in men's use of violence against their partners.

D[2]4: I was very drunk that night (*punched partner*).

F1: He's got an alcohol problem that is related to his use of violence.

S7: If he (*partner*) was drunk, then I had to be careful

Alcohol has an impact in a range of different ways, as captured by the following four first level themes.

First level theme: '*I blame my drinking for me being violent'*

Some of the participants used a 'blame' narrative to explain the relationship between IPV persistence and alcohol. Both the persisters and desisters said that alcohol was a mechanism that they could use to 'explain' or justify their behaviour.

> **D7:** I don't know. I suppose a lot of it was, well especially in the early days afterwards I would just put it (*the episode of violence*) down to just blame on drink really, you know, we were pissed up so somebody or something else's fault, usually alcohol.

This narrative was used frequently; as participants described how they rationalised that 'it was the drink that made me do it' [**P10**].

First level theme: 'We were both drunk and violent'

Participants described how IPV was more likely when both parties in the dyad were drinking alcohol.

D5: It (*IPV*) was all alcohol induced, both drinking.

D7: Our relationship and violence was based on alcohol.

[2] When presenting quotes from these data, the following codes are used: S for survivor, D for desister, P for persister and F for facilitator.

Persistence was associated with both partners drinking (to excess in many instances) followed by episodes of IPV that could be instigated by either of the dyad but usually resulted in both using violence.

> **P7:** I was a nightmare when I got drunk, my wife had alcohol issues so that always ended in conflict. We couldn't just have a drink it would have to be get drunk. Something would happened you know and we would get drunk, there'd be an argument or an incident (*of violence*) And it was never any just social drinking. It was, let's get drunk drinking. And that then progressed to both being violent.

First level theme: 'We have drunk arguments that get out of hand'

A consistent theme in the data was the narrative that alcohol made individuals more argumentative, which perhaps is related to behavioural disinhibition, as this escalated to physical violence.

> **P8:** Yeah it was just a drunk argument that got out of hand I think. We both had a lot to drink and we were both getting mouthy and abusive verbally towards each other I punched our bedroom door then just pushed her on the bed.

This was also observed in the survivors' narratives. Several alluded to the fact that when their partners had been drinking heavily, they became more argumentative and that the arguments became more heated as 'drink made the argument worse' [**S3**].

First level theme: *'Alcohol makes me more emotionally reactive'*

Alcohol was described as triggering emotional reactions that were associated with the use of IPV. A desister, reflecting about when he was violent, identified that drinking affected him emotionally in different ways, with different consequences.

> **D3**: Alcohol's a nightmare for me….But if I drink and things are good I'm amazingly great. If I drink and I'm threatened then I'm an absolute nightmare.

> Because it heightens my emotions. So the emotions that I can't control.. so I that snapping point that's fast is like razor sharp and I am violent.

This perhaps is evidence of emotional disinhibition and amplification. Others described how drinking alcohol affected their emotional reactions, e.g., they felt 'more wound up' [**D9**], or it 'lowered their inhibitions' [**P1**], or a survivor noted that it 'made him (*her partner*) angry and it made him violent [**S6**].

> **D13**: I lost all self-control sort of thing, I drank more than you should in a week in one night… it lowers your inhibitions. May be if I hadn't been drinking, if we'd had the same argument then, it wouldn't have happened if I'd been sober I wouldn't have grabbed her by the throat.

Overarching Theme: Desistance narrative, 'Address my use of alcohol'

Men had to change their drinking patterns and either manage their own drinking, or with their partners had to both manage their drinking, or not use alcohol as an excuse to be violent. Regardless of how the men perceived the role of alcohol in their relationships and use of IPV, they realised that they needed to face up to the fact that alcohol was problematic and that they needed to take some sort of action.

> **D1**: So the key was with this period of time when there was no alcohol. That was the biggest thing that helped me to stop being violent.

> **F6**: They get to where they're kind of able to say oh I can't believe I did that (using violence), you know, I've got to stop drinking, and I've got to change

First level theme: *'I need to manage my drinking'*

This theme represents the men's realisation that alcohol was a trigger to IPV or played a role in their use of violence against their partners and consequently that not drinking would help them not to use IPV. This was predominantly a feature of the desisters' accounts, supported by the survivors and facilitators; it was rarely seen in the persisters' accounts.

Some desisters described that they had cut down their drinking to manageable, sensible levels, e.g., 'I do drink, but I don't drink to excess' [**D2**] Some completely stopped drinking alcohol (e.g., 'No alcohol then, so it (*IPV*) all stopped [**D10**]; 'We've had desisters who just stopped drinking..and we know have not reoffended [**F5**]).

> **D10:** Well the thing is last year I stopped drinking as well..Yeah I used to go out you know and have a few drinks and be really opinionated....and now I am much more level minded.

> **S3:** But now he doesn't want the drink....He's learnt to control it (*his behaviour*) without the aid of whiskey...it's easier for him to control.

By removing this factor the desisters eliminated a risk factor that commonly played a role in their use of IPV. The persisters who identified that this change was required had either just stopped drinking, or were in the process of stopping:

> **P8[C]:** The biggest battle I have is with alcohol still.....And managing that is still the biggest problem....The thought processes about going to buy a bottle of wine are instant thought processes.....So I need to control those.

First level theme: *'We both managed our drinking'*

Where alcohol was used by both partners and contributed to IPV, the process of desistance was aided by both partners ceasing their use of alcohol: 'We was not drinking. We did not have a drop of alcohol' [**D8**]. This could occur for a range of reasons; for example, the partner being pregnant.

> **D5:** There wasn't any violence when (*son*) was inside her really. We'd still argue and bicker. But we wouldn't be going to the pub. So we would stay in our flat and we

would get a lot of movies in. And just watch movies together and both stop the drink. There was bickering but because there was no alcohol it didn't escalate.

Another desister [**D9**] explained how he managed social situations with his partner; e.g., one of them would drive, they would take the children with them, so that they could avoid heavy drinking sessions, which stopped violent arguments between them as a couple.

First level theme: 'Stop using alcohol as an excuse'

Several desisters reflected on how they realised that they used alcohol as an excuse e.g., 'I used to blame alcohol for being violent' [**D11**].

> **D10**: I used to use alcohol as an excuse; I don't believe alcohol is an excuse, at the end of the day if you are a straight guy and you are drunk you would not have sex with another guy

Demonstrating the importance of this as a treatment goal, several facilitators explained how they used examples to demonstrate how alcohol could, but should not be used to explain or justify violence.

> **F3:** We say have you ever been drunk in front of your mother and they yes and then have you ever hit your mother when you were drunk and they say no. And I say why have you not hit your mother, because I respect my mother, well so no matter how shit faced drunk you are, it doesn't matter you won't hit your mother, and then so why can't you just extend that respect to your partner. I've seen it work on three different men.

Discussion

This is the first study to specifically examine the role of alcohol in the process of desistance from IPV and therefore makes a unique contribution to our understanding of this issue. The findings showed that although there were no differences in self-reported alcohol

dependency between desisters and persisters on the MCMI-III, desisters reported having changed their use of alcohol in order to facilitate their cessation of violence.

Alcohol abuse has been extensively cited as a risk factor for IPV [28-31]; with some suggesting that it is one of the most important risk markers for IPV [32]. The findings of the quantitative analysis provide further support for this, since both IPV groups presented with higher proportions of clinically significant traits compared to the control group. Nearly half of the desisters and two-thirds of the persisters had elevated BR scores on the alcohol dependence scale. Clinically elevated scores on this scale means that an individual has a history of problematic drinking or personality traits frequently seen in alcoholics [33]. These elevated scores are in line with previous research that has found high rates of alcohol dependence in IPV perpetrators [34]. Scores on this scale correlate with behaviours associated with alcohol abuse, such as depression, dependence anxiety and extroversion. These factors were not investigated in the current study, and research is needed to investigate the interplay between these factors.

Little attention has been paid to whether alcohol use can distinguish desisters from persisters and the quantitative element of this study revealed that the MCMI-III could not differentiate these groups. This is perhaps not surprising since *history* of alcohol abuse is assessed by this scale. Although this static factor has been extensively associated with IPV, the findings of this study highlight that it is important to understand both historical and *current* alcohol use. This provides further support that attitudes towards the use of alcohol, and limiting, or eliminating alcohol consumption is an important goal in the process of desistence from IPV. This also means that the MCMI-III should not be used as a measure of treatment change or post-intervention. However, assessing change in use of, and thoughts about the use of alcohol, in some instances of both the IPV perpetrator and his

partner, is recommended. The MCMI-III includes questions that are used to measure traits associated with the behaviours being examined, i.e., attitudes associated with problematic drinking and reflecting behaviours associated with problematic drinking. The alcohol subscale measures traits such as impulsivity, selfishness, independence, non-empathic behaviour and irresponsibility. These might distinguish desisters from persisters and if so, might be useful measures of change/progress. A clinical interview is required to determine if and how an individual has been abusing alcohol and then if this relates to their use and non-use of IPV. Research is required to assess this.

The qualitative data revealed that the majority of participants in this study associated alcohol use with IPV. Drinking alcohol was perceived to increase the likelihood of violence and arguments, influencing emotional reactions and disinhibition. Heavy alcohol use has been proximally related to aggression through its psycho-pharmacological effects on cognitive function [8]. It has been suggested that heavy drinking can lead a person to overreact to perceived provocation, misjudge social cues and reduce the saliency of cues that aggressive behaviour will have negative consequences; these factors increase the risk of confrontation and violence [35] . This is supported by the findings of this study, as these features were described in individuals' persistence narratives.

It has also been identified that alcohol may have a spurious link to IPV, in that it may be used as an excuse or justification [17], where individuals use forms of 'deviance disavowal' [36], e.g., blaming alcohol post hoc, drinking so that others will excuse their behaviours based on them being drunk, or drinking to embolden them to use IPV. This was seen in the interview data. In particular, alcohol was described as enabling individuals to justify their use of IPV and in doing so repeat this type of behaviour. However, this was also something that was reflected on in relation to desistance, in that an acknowledgement was made by

desisters that they had actively stopped seeing alcohol as something they could rationalise and on which they could blame their use of IPV.

In the desistance narratives, men described their (and in some instances also their partners) abilities to manage their drinking of alcohol, which was achieved by complete abstinence, or significantly reducing alcohol intake. In relation to general offending and delinquency, it has been found that when individuals understand the relationship between their alcohol use and offending and stop drinking, this is more likely to change their life-courses and put them on to the path of desistance [37]. This has not been examined specifically in relation to IPV; however, in alcohol dependent individuals, IPV is substantially decreased following treatment for alcohol use [3,20]. Desistance from IPV is made up a range of psychological and social processes that individuals experience and is dynamic as men have to take an active role that involves hard work and commitment [22]. It would appear that for some, part of this involves actively managing their use of alcohol, although this likely to be only one of many factors that need to be addressed.

It therefore appears that the MCMI-III alcohol dependency scale cannot distinguish the desisters from the persisters. This might be because this scale examines historical alcohol use, which is just a likely to be present for desisters as persisters, as this is a common risk factor associated with IPV [28-31]. However, the qualitative data indicates that use/non-use or management of alcohol is important for desistance, as this was a factor that individuals consistently described as being associated with their abilities to desist. In order to understand this more clearly, scales that measure current drinking patterns, and that are administered longitudinally over a period of time might be of more value in distinguishing desisters from persisters. This needs to be addressed in future research, as it will provide insight into *if* alcohol plays a role in the process of desistance. In addition the qualitative

element of this research also needs to be extended overtime, by following perpetrators through a period of change as this will give a deeper insight into *how* alcohol plays a role in the process of desistance form IPV.

Limitations

The findings need to be interpreted within the context of the study's limitations. Alcohol dependency was based on a self-report measure (MCMI) taken at one time point and reductions in alcohol use were discussed in interviews. No measure of alcohol amount, frequency or withdrawal was used in the study. As amount and frequency of alcohol intake is associated with IPV [38,39] this is likely to be relevant. Withdrawal may also be important in relation to attitudes to and behaviours related to IPV. It is known that alcohol withdrawal for example, contributes to a state of distress and psychological discomfort, including emotional changes, irritability, altered mental state, agitation, anxiety, insomnia and anhedonia [40,41]. Assessing change in drinking behaviour over time using an appropriate measure would enable a more thorough understanding of the change in use of alcohol over the process of desistance.

Group classification was based on self-report using the CTS2 [24], which can be problematic [42] and is not a guarantee of desistance. This was cross-checked with file-notes that should have flagged police call-outs; however, as police contact data is a proxy measure of IPV [43], this does not guarantee desistance as it naturally does not include unreported episodes. Desistance was defined as an absence of physical violence which is a narrow definition of IPV, as it is acknowledged that IPV comprises a range of non-violent and coercive behaviours [44]. Sexual and psychological violence also need to be examined to gain a more complete understanding of the role of alcohol and all forms of IPV.

The sample across the four groups was predominantly White British. It has been suggested that cultural and ethnic differences affect how the process of desistance is experienced [45], which needs to be considered in future research studies. All offenders had attended treatment, with individuals who have not been referred for treatment constituting a large proportion of IPV men [46]. The findings are therefore not generalisable to those who have not been referred for treatment, i.e., those who live in the community but have never been arrested or never voluntarily sought help / treatment, or to non-white British groups/cultures.

Finally, in qualitative research, it must be ensured as far as possible that the findings are the result of the experiences and ideas of the participants rather than those of the researcher [47] . The researcher of the current study has previous research experience and knowledge of the topic area, hence it is possible that this may have influenced the way the data was collected and analysed. However, in order to mitigate these potential biases, a number of practices were employed as per the guidelines proposed by Shenton [48] to reduce bias and promote the credibility and confirmability of the research.

Implications

The focus of intervention should be on current practices, attitudes and behaviours in relation alcohol use, as this, rather than a history of alcohol use, seems to be what differentiates desisters from persisters. Current attitudes towards and use (or non-use) of alcohol are therefore important treatment targets. Treatment should be based on individual needs, which for some might mean the inclusion of integrated or adjunctive treatment for alcohol abuse. Furthermore, with individuals for whom alcohol use was a feature of their perpetration of IPV, it might be possible to use assessments of these behaviours and attitudes to identify men who are making progress on their pathways to desistance. Using

the clinical scale of the MCMI-III should not be used for this; however the trait measures of this inventory might be suitable.

Longitudinal research should be undertaken to understand over time how alcohol is related to the process of desistance by examining within-individual changes (in alcohol use and IPV). Research is also needed to examine the role of dynamic risk factors and their associations with alcohol use and IPV, as they could provide fruitful avenues of intervention.

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Table 1: Characteristic of sample and subsample for quantitative and qualitative analysis

Study	Group	*n*	$^{\Delta}$C(SR) (*n*)	▲P(CM) (*n*)	Stage of treatment (*n*)			Age Range	M_{Age} (*SD*)	% White British
					Pre	Attending	Completed			
Quantitative Analysis										
	Controls	49	0	0	*N/A*	*N/A*	*N/A*	21-74	41.0 (10.4)	100.0
	Desisters	37	13	24	0	22	15	23-66	38.6 (9.5)	89.2
	Persisters	50	21	29	15	35	0	19-59	35.0 (9.7)	92.0
Qualitative Analysis										
	Desisters	13	4	9	0	9	4	24-55	38.0 (10.3)	92.3
	Persisters	9	2	7	2	7	0	26-50	36.0 (8.1)	88.9
	Facilitators	9	*7	*2	*N/A*	*N/A*	*N/A*	28-55	43.7 (9.1)	100.0
	Survivors	7	*3	*4	*N/A*	*N/A*	*N/A*	28-62	49.14 (7.19)	100.0

$^{\Delta}$C(SR) self-referred to community programmes
▲P(CM) court-mandated through probation
*denotes if facilitators delivered the programmes to C(SR) or P(CM)
*denotes if survivors' partners were C(SR) or P(CM)

Table 2: Median, mean and standard deviations by group, and Kruskal-Wallis and post-hoc Mann-Whitney on alcohol dependency scores

Group	*n*	Median	Mean (SD)	H (*r*)	Control vs. Desister *z* (*r*)	Control vs. Persister *z* (*r*)	Desister vs. Persister *z* (*r*)
Control	49	23.00	30.00 (25.48)				
Desister	37	67.00	64.40 (18.75)	50.49* (.58)	-5.56* (-.57)	-6.42* (-.67)	-1.18 (-.13)
Persister	50	71.00	67.86 (21.46)				

*$p > .001$

Table 3: Percentages of clinically relevant scores for alcohol dependency, significance of group on scores and post hoc differences

BR Scores	Control	Desister	Persister	Group $\chi^2_{(2)}(V)$	Control vs. Desister $\chi^2_{(1)}(V)$	Control vs. Persister $\chi^2_{(1)}(V)$	Desister vs. Persister $\chi^2_{(1)}(V)$
% where BR>74	4.1	35.1	40.1	19.06*	.37	18.47* (.43)	.21 (.05)
% where BR>84	0.0	8.1	20.0	11.57*	.29	10.90* (.33)	2.37 (.16)

*$p > .001$

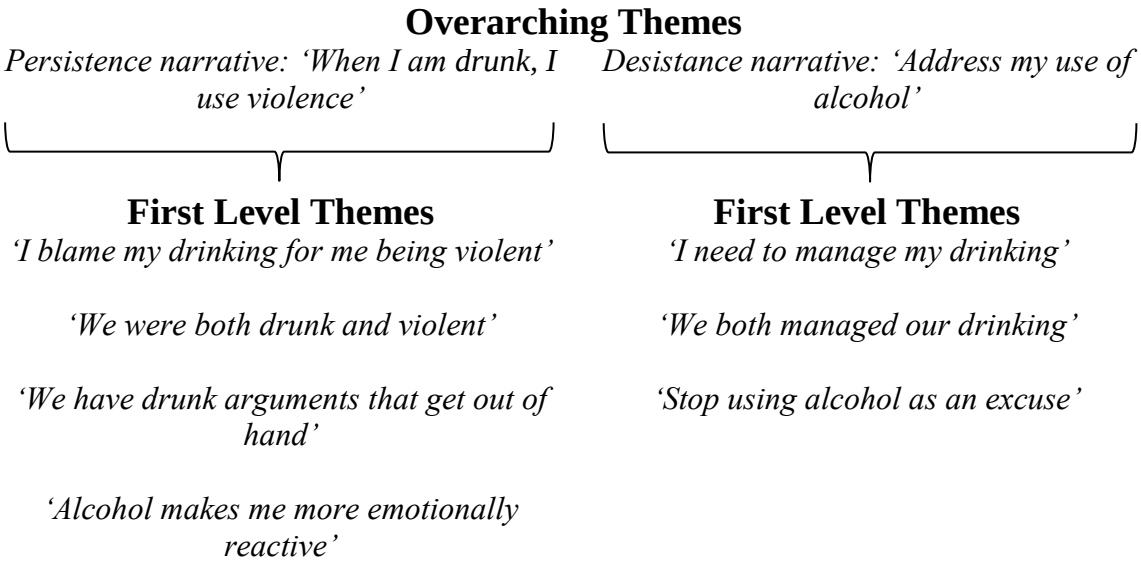

Figure 1: Themes developed from participants' narratives