Couple Relationships in the Context of Heroin Use

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“We’ll be on different pages, you know” The Lived Experience of Being in an Opiate Using Couple whilst in individual treatment for Opiate Use

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Thesis Portfolio Abstract

Background: Recent prevalence studies of opiate users within England estimate there to be over 250,000. Opiate users make up 53% of people in drug treatment services. Although retention in treatment improves treatment outcomes, dropout rates remain high. Intimate relationships may be an influential factor in opiate users' treatment and recovery, however limited research has been conducted to understand the experiences of opiate using couples (relationships where both members use opiates). This project sought to examine how these relationships are experienced and how they may influence individuals' attempts to reduce opiate use. **Design:** This portfolio reports a meta-ethnographic approach to the synthesis of the qualitative literature on the relationship experiences of opiate using couples; and an empirical study exploring the lived experience of individuals in treatment for opiate use whilst their opiate using partner is not in treatment. This study adopted an Interpretative Phenomenological Analysis method. **Results:** The systematic review synthesised findings from 27 studies, developing six high order themes; centrality of opiate use to the relationship, stabilising and destabilising features of the relationship, relationship and addiction reinforcers, negotiating treatment, and gendered power dynamics. The empirical paper produced themes of how opiate users in treatment rationalise but also re-evaluate their relationship, whilst conceptualising their recovery and experiencing a disruption to their sense of identity. **Conclusion:** The systematic review suggests that opiate use plays a complex and reciprocal role within couple relationships, and also demonstrates how individuals may negotiate treatment and recovery from within opiate using relationships. The empirical paper posits that individuals in treatment for opiate use undergo a number of challenges in optimising their treatment experience, and illuminate the dilemmas faced by individuals when remaining in their relationship whilst simultaneously reducing their opiate use.

Table of Contents

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Chapter One

Systematic Review

"It bonds you even closer" - The Relationship Experience of Individuals within Opiate Using Couples: A Qualitative Systematic Review

This paper has been developed for submission to Drug and Alcohol Dependence. Author Guidelines are outlined (Appendix A). For clarity, a notable author guideline in reference to this review is that all Figures and Tables can be provided at the end of a manuscript and therefore are labelled as appendices and placed at the end of this portfolio. Word Count Limit 6,000

Word Count: 5,996

"It bonds you even closer" - The Relationship Experience of Individuals within Opiate Using Couples: A Qualitative Systematic Review

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Abstract

Aims: This review paper aims to synthesise the existing qualitative literature on opiate- using couple relationships to identity implications for clinical application and research, and to determine gaps in the literature.

Methods: Medline, PsychINFO, Embase, CINAHL and Scopus were systematically searched for articles published from inception to January 2019. Inclusion criteria were that studies used qualitative methods to explore couples' relationships in the context of opiate use.

Results: The search process yielded 10,964 papers. After assessment of eligibility, 27 studies were included. The centrality of opiates within couple relationships is a reported theme in terms of sharing opiates, bonding through opiate use and primacy in the relationship. Relationships are constructed as unique, sites of safety, through care, love and intimacy. However, relationships are also undermined by the influence of heroin, most significantly through conflict, impaired sexual intimacy, jealousy and mistrust. A link between the relationship and opiate use is highlighted through the high order themes of intimacy in drug practices, care and collusion, enmeshed relationships and social alienation. Partner influence in negotiating treatment for opiate use and gendered dynamics were also discussed.

Conclusions: This review provides insight into the complex relationships of opiate using couples, highlighting the positive aspects to their relationships, but also how opiates become foundational to these relationships, creating an environment where the relationship can be undermined or destabilised. Clinical implications include considering assertive outreach for couples, utilising couples-based approaches and prioritising screening for domestic abuse within these relationships.

Keywords: opiate, heroin, addiction, couples, meta-synthesis, qualitative

1. Introduction

Most recent prevalence studies of opiate users estimate there to be over 250,000 opiate users in England (Public Health England, 2018). Treatment of 141,189 people with opiate use dependence, mainly heroin, comprises 53% of the total numbers of people receiving treatment for any drug or alcohol use problem (Public Health England, 2018). With respect to the relationships of opiate users, whilst there are no official statistics for couples who use opiates together within the United Kingdom, survey data in Australia indicating 50% of participants who share injecting equipment do so within their intimate relationship (Iversen and Maher, 2015), and previous studies have revealed similar results (Pivnick et al., 1994).

In the UK, treatment dropout rates for opiate use remain high. The National Drug Treatment Monitoring System (NDTMS) reports that 40% of users dropped out of treatment between 2017-18 (Public Health England, 2018). Although reasons for treatment discontinuation are not specified, there is research highlighting the impact of opiate users' intimate relationships with other opiate users on relapse and recovery (Notley et al., 2013) and that relationship characteristics can influence drug use within the relationship (Cavauiti, 2004).

A biopsychosocial model of addiction posits the influence of biological, psychological, social and cultural factors in the maintenance of substance use problems (Griffiths, 2005; Skewes & Gonzalez, 2013). In considering social influences on substance use, Griffiths (2005) highlights the reinforcing nature of peer and social groups in continued drug use or other addictive behaviours. Systemic theories of addiction including Social Ecology and Stress-Strain-Coping-Support (SSCS) models highlight the significance of social and intimate relationships in the maintenance of problem substance use (Adams, 2008; Orford et al. 2013). With that considered, however, less research attention has historically

been placed on the social context of addiction, predominately conceptualising addiction problems from within the individual user and internal processes such as motivation, cognition and behaviour (Copello & Orford, 2002; Copello & Walsh, 2018). Qualitative research with drug using couples, has focused predominantly on those who inject opiates such as heroin, exploring the relationship dynamics, including how care in relation to opiate use maintains dependency (Simmons, 2006), relationship commitment, benefits and problems (Stevenson & Neale, 2012) and intimacy and care (Rhodes et al., 2017). The research on couple relationships of opiate users comes from diverse sources in terms of culture and context, investigating experiences of treatment for opiate use or other health conditions, injecting drug practices, drug initiation and sex work. Additionally, some qualitative research has explored gendered experiences of these relationships, naming power imbalances and gender influenced aspects to opiate initiation (Brady & Randall, 1999) and continued use (Amaro & Hardy-Fanta, 1995; MacRae & Aalto, 2000). This highlights a further question of how these relationships are negotiated and experienced in relation to gender.

The qualitative literature to date offers some insight into the complex interpersonal dynamics of opiate-using couples; however, there has been no attempt to review and synthesise this literature in consolidating and articulating key concepts of these relationships. The aim of this systematic review is therefore to synthesise the literature with the aim of understanding opiate users' intimate relationships, contributing to an integrated understanding of how these relationships are experienced in ways that are conducive but also detrimental to the individual and also how gender influences the relationship experience.

To explore the relationship experiences of people who use opiates within relationships, this review systematically synthesised studies with a qualitative component. The protocol was registered in PROSPERO (Workman et al. 2018). Review questions were:

- What relationship experiences do people in opiate-using couples have?

- What are the perceived benefits and difficulties for people in opiate-using relationships?
- Are gender identities/roles adopted and expressed in relation to opiate related activities?
- If so, how are these roles demonstrated/experienced between the genders?

2. Methods and Materials

2.1 Search Strategy

Comprehensive searches of EMBASE (Ovid), CINAHL (EBSCO), PsychINFO (EBSCO), MEDLINE (EBSCO) and Scopus databases were undertaken from database inception to January 2019. Qualitative study limitations were not applied. Index terms describing opioid addiction were combined with index and free text terms describing intimate relationships (Appendix B). Additional searches of grey literature and hand-searching journals were undertaken.

2.2 Study selection

The PRISMA diagram demonstrates the study selection process (Appendix C). In the first stage of study selection, duplicates were removed before a detailed title and abstract screen was undertaken independently by one reviewer (PW*)* based on six inclusion criteria: (1) Qualitative studies exploring aspects of relationships in drug- using couples (these may include other drug users, but analysis will be performed on participants reporting opiate use as the couple's primary drug use), (2) Mixed methods studies that include qualitative information on drug using couples, (3) Adult population studies, (5) Written in English, (6) With no time restrictions (from databases inception to January 2019), and one exclusion criteria: (1) Quantitative studies on drug using couple relationships.

Full text papers were retrieved for all potentially eligible papers and uploaded into the referencing software Mendeley. Within this database, a full title and abstract screen was

methodically undertaken by the lead researcher (PW). During this process, each eligible paper's title and abstract was evaluated for its relevance to the review and in relation to the review inclusion criteria. Based on this approach, each study was put either to the full text screen stage or excluded from the review. A secondary researcher (JG) undertook a screen of 25% of the title and abstract sample. Of the 25% sample, there was disagreement on 12 papers. Disagreements were resolved through a consensus meeting of reviewers. Of the 10,967 records, 110 articles were selected for full text screening. During the full text screening, the lead researcher (PW) screened all the papers and a secondary researcher (LM) assessed a 20% random sample, which was selected through a random sample generator using Microsoft Excel software. Disagreement between PW and LM occurred for one of the 20% sample papers. The third researcher (CN) reviewed the discrepancy, which was resolved by consensus.

2.3 Assessment of study quality

The Critical Appraisal Skills Programme (CASP) checklist, was applied independently by two researchers (PW & LM). Recommended by the Centre of Reviews and Dissemination (CRD, 2009), the CASP was created for use in qualitative systematic reviews and consists of 10 questions. Each study was rated against the CASP checklist for each of the questions, scoring 1 if the standard was met, 0.5 if partly met and 0 if not met. Disagreements were resolved through discussion with the third researcher CN. Studies were included in the synthesis regardless of CASP score.

2.4 Data Extraction

Data was extracted on the country of origin of the study, sampling technique, sample size, study design and analysis method (Appendix D). Qualitative data of each study's reported participant discourse and associated author interpretations were extracted into NVivo Version 10 software for analysis. Some study participant data did not meet criteria for

the systematic review questions (i.e. accounts of other drug type); therefore, all attempts were made to remove these narratives from the analysis.

2.5 Data Analysis

The primary researcher extracted data of all author and participant accounts from the results sections of each study relevant to the review questions. All data was analysed using qualitative meta-synthesis methods (Paterson et al., 2001), informed by Noblit and Hare's (1988) meta-ethnographic framework, which proposes three main strategies: reciprocal translations analysis, refutational analysis and lines of argument synthesis. A perceived strength of meta-ethnography is that it synthesises diverse sources, which lends itself well to the diversity of the considered literature in this review. Schutz (1962) outlined that this process can lead to the development of the first order constructs of the original participants and the second order themes constructed by the authors to third order constructs developed in the meta-synthesis (Campbell et al, 2006). This meta-synthesis was additionally conducted from a social constructionist position (Burr, 2003), taking into account the specific social and cultural context of the individual.

The analysis process followed the steps of Noblit and Hare's (1988) meta-ethnographic framework. Given that this framework is sometimes unclear in its approach to certain stages of analysis (Atkins et al, 2008), the process was further supported by worked examples and reflective accounts of meta-ethnographic analysis within healthcare research (Britten et al, 2002; Atkins et al, 2008; Cahill et al, 2018):

Reading the studies

During the initial stage of analysis, the primary researcher read carefully through the selected papers to identify the main concepts of each study. At this stage, details of the study, including participants' demographics, study characteristics, analysis method and findings, were recorded (Appendix D).

Determining how the studies are related

The relationships between the concepts arising from papers were considered. The primary researcher coded all narratives before codes and emerging themes were examined in relation to others within the study and across the other studies, through constant comparison. The main concepts and themes were identified, and contradictions noted between reports.

Translating the studies into one another

Within this stage, Noblit and Hare (1988) describe comparing the concepts within one paper with the concepts in others. Through the aforementioned process of constant comparison, it was possible to establish relationships between the concepts and metaphors of the included studies. These relationships seemed reciprocal in nature and a consensus of themes were identified and refined into third order concepts or themes. Atkins et al. (2008) suggest arranging the research papers in chronological order, translating the concepts from paper one to paper two and then translating concepts from paper two to paper three etc. Additionally, theme development was also supported by team discussion. An excerpt of theme development is shown in Appendix E.

Synthesising translations

This stage involves a shift from a descriptive to an explanatory analysis (Atkins et al., 2008). As mentioned previously, through translating the studies into one another, studies are not refutations of one another, even when particular concepts are not identified in all papers. The relationships between papers seemed reciprocal in their shared concepts and a line of argument could be developed. Within a line of argument synthesis, a new understanding of a phenomenon can be developed by synthesising the first and second order themes within the study texts (Atkins et al., 2008).

Expressing the synthesis

In expressing the synthesis, a number of methods can be used, including diagrams and other visual representations (Cahill et al., 2018). However, given the complex and interacting nature of the synthesised concepts, it was agreed as a research team that a written narrative of the synthesis would be most appropriate in expressing the findings.

3. Results

10,967 records were screened at a title and abstract level. 110 records were assessed for eligibility by examining the full text. In total, 26 studies reported in 27 papers were included. This is outlined in a PRISMA diagram (Appendix C). These papers examined various aspects of couple relationships in the context of drug use, including opiates across a variety of cultural and contextual settings. Most studies were of high to moderate quality, with two studies scoring low in quality. Researcher reflexivity, with regards to the relationship between the participant and researcher for example, was often not included or inadequately described. Study characteristics and CASP ratings are outlined in Appendix D.

In total, 679 first level codes were identified and organised into 44 interpretative codes. The first level codes were organised around the review questions before being synthesised into seven core themes: centrality of heroin, relationship constructors, relationship destabilisers, relationship-addiction reinforcers, negotiating recovery and gendered power dynamics (Appendix F). The superordinate and subordinate themes are outlined below, each theme drawing on participant and author narratives (examples of participant accounts and author interpretations are provided in Appendix G).

3.1 Centrality of Heroin

A large proportion of individuals reported *sharing needles and drugs*, a number of whom described sharing these exclusively within the relationship. The most notable reason for this was that it represented a unified relationship.

Furthermore, *heroin bonding* or when heroin use within the relationship appeared to stabilise the relationship, was noted. The centrality of heroin features as a main driver in bond development and the relationship persisting. Conversely, one study interpreted that heroin use within the relationship enabled the masking of difficult relationship experiences which would be intolerable outside of a heroin using partnership.

A large quantity of female participants reported their current or past male *initiating heroin use within the relationship* and establishing continued use. Sometimes it was explained that heroin not only became a key feature of the relationship but was given priority over other relational aspects, *heroin is given priority* or comes first in the relationship.

Additionally, a number of experiences of *joint heroin-related activities were discussed* in which couples would form partnerships through obtaining heroin and the funds for heroin. This was often through drug selling or other methods of pooling resources.

3.2 Relationship Constructors

A large number of participants in the studies articulated candidly their sense of their relationship being a *unique relationship* and having special qualities that represented a committed partnership.

Additionally, the relationship being a site of *safety* was also noted, particularly for female participants who reported their male partners offering physical safety in what can be a threatening and hostile environment.

Reciprocal care was a key valued feature in a number of the relationships across studies. This appeared to take many forms such as emotional, financial and physical support.

Across a number of studies, *love and intimacy* towards their partner or reciprocal love was expressed by participants. Romance and intimacy featured prominently in their descriptions and how love was expressed. Love was also often emphasised in unconditional and absolute terms.

Within relationships where partners who knew both they and their partner were HCV positive, there seemed to be a discourse of how shared health status reinforced the relationship, both forming a relational boundary and also how this shared knowledge and experience fostered trust and intimacy.

3.3 Relationship Destabilisers

Individuals expressed experiences of *conflict* within the relationship. The most prominent example of conflict in the relationship was in the form of domestic violence and emotional abuse, most frequently with the male partner as the perpetrator.

Relationship tension and conflict was often linked to heroin and drug use, particularly occurring around equality of drug division and sharing drug resources.

Further to this, participants expressed their belief that *heroin use undermines the relationship*. This took the form of undermining the relationship and fostering an erratic and sometimes chaotic nature within the partnership.

Heroin use in the relationship also appeared to interfere with the sexual aspects of couple relationships, most notably in *impairment of sexual intimacy*.

The presence of *jealousy and mistrust* within the relationship was also reported, namely seen as expressed by the male towards the female. This was most notable when the female was separated from her partner within service contexts such as hostels or treatment programmes but also within her social network.

3.4 Relationship-addiction Reinforcers

There appears to be experiences or phenomena that occur in the relationship that display constructive but parallel restrictive qualities to both the individual and the partnership. One such phenomena is the expression of *intimacy in drug practices*. Participants described how relationship qualities of intimacy and affection were expressed within heroin use, including within injecting practices. In one such account, allowing his

partner to inject first, despite the risk of HCV transmission, was described in terms of romantic elements.

Within their respective studies, Simmons and Singer (2006) and Simmons and McMahon (2012) identified the theme of *care and collusion* within heroin using couples. This concept identifies the expressions of care in colluding with the mutual heroin dependence, most often expressed when partners are experiencing, or at risk of experiencing, heroin withdrawal and individuals enact care through helping their partner manage withdrawal through the procurement and providing of drugs. These expressions are explained as maintaining heroin dependence.

The concept of the *enmeshed relationship* encapsulates the observation made that the couples become progressively co-dependent upon one another, which in turn, impairs their individuality and compounds their social isolation.

As the couple relationship develops, it appears that the social networks of the individuals dissipate, leading to social isolation or *social network alienation*. From the individuals that referred to this process, it seems that this in turn enmeshes the relationship, as the individuals begin to rely solely on their partner.

3.5 Negotiating Recovery

Of those participants who were reported to be in treatment for their heroin use, some alongside their partners, one of the most prominent beliefs was that their *partner influenced relapse,* in that both relapse or difficulties in heroin reduction were likely if their partner continued to use or they relapsed. It appeared that a relapse in their partner's heroin use cascaded to the other, creating a permissive environment to then use. It was also recognised that being in a relationship with another heroin user was itself a barrier to accessing drug use treatment. This was often rationalised as worry and guilt for the partner they leave behind and also the anxiety of losing the relationship in the process.

That considered, *aspirations for the relationship to be abstinent* are articulated by participants who often expressed their hopes for their relationship to be drug free, wanting to reduce their heroin use together and build a meaningful relationship without heroin. Often, the participants who had entered treatment alongside their partners found that the relationship was a necessary vessel for treatment engagement, citing mutual support and love for each other as key facilitators of heroin reduction. From these experiences, there is a narrative here of the *relationship influencing recovery*.

3.6 Gendered Power Dynamics

When accounts of the roles of each member of the relationship in drug procurement were discussed, it was often the male participants who were described as the primary providers, the *male provider*. This gendered role of the male as provider was also expressed in other facets of the relationship, including expectations of financial security. This was often described as a normative gendered role of the relationship. However, with that considered, females also took an active role in drug procurement and in funding the couple's heroin use. This was often seen as incongruent with normalised gendered roles.

Female participants demonstrated an awareness of power imbalances within the relationship, a prevalent theme of the literature being of *males exerting control*. This was notable within drug related practices such as drug use, drug division and injection order, as well as with regards to relationship finances and females' social networks.

Within this complex power imbalance dynamic, there were instances of females attempting to assert authority in the relationship. A number of individuals who described this, explained leaving or threatening to leave the relationship to redress the inequity or making demands on their partner that enabled the female to express some authority in the relationship. Within these discourses, it was evident that the relationship was often experienced as a *power conflict*.

4. Discussion

This review has synthesised the literature on intimate relationships in the context of opiate use, exploring the relationship experience and how gender roles are experienced within these relationships. Themes include the positive and negative experiences in the relationship and how some of these are inextricably linked, the centrality of opiates within these relationships and how opiate treatment and health considerations are negotiated between members of the couple.

The themes interacted in complex ways; this review has outlined the categorically positive and negative experiences within couples but also instances where accounts appeared to converge and became inextricably linked, particularly in the context of opiate use. Opiates were frequently seen as central to the relationship, providing stability or a sense of togetherness, a finding supported by the findings of Fals-Stewart et al. (1999), which suggests that when both partners are using drugs, relationship satisfaction and stability are associated with increased drug use.

The intimacy expressed through shared opiate use practices often compounds the couples' opiate use as they come to view it through a prism of affection and familiarity. The complex dynamic of care and collusion again reinforces the cyclic nature of opiate dependence through expressions of care. Also, the enmeshed nature of these relationships demonstrates that the relationship is a site of social and physical protection from the adversity these couples face within their environment. At the same time, the co-dependence that the individuals experience within these relationships appear to perpetuate their social isolation, proximity to the antecedents and opportunities for continued opiate use. Ideas from co-dependency theory often underlie self-help groups, including Narcotics Anonymous and Alcoholics Anonymous (Simmons & Singer, 2006). However, this theory has been criticised and its application to drug using couples, disputed (Haaken, 1990). Interpersonal and

relational difficulties within the drug using population have been acknowledged from an attachment perspective, noting that drug misusing individuals with insecure (Thorberg & Lyvers, 2010; Borhani, 2013), avoidant (Piehler et al. 2012) and preoccupied (Doumas et al., 2007) attachment styles experience greater problems with relationships. Howe (2011) notes that drug users find it difficult to form relationships with emotional depth, whilst Davila and Bradbury (2001) describe drug misusing individuals' propensity to remain in unhelpful relationships. Relationships seen as sites of physical and emotional safety also draw some parallels within attachment literature, where the concept of felt security highlights the need for proximal social experiences (Wallin, 2007). This offers some theoretical insight into how individuals often appear to remain in 'enmeshed' relationships, despite the apparent detrimental effect it has on them and on their lives.

The themes interacted in complex ways also with regards to treatment for opiate use. The relationship itself can be viewed as a barrier but also as a facilitator to entering treatment, with the individual experiencing the dilemma of how treatment may affect the relationship or what will happen to their partner should they commence treatment. That considered, if both partners were to enter treatment, the relationship and the positive relational aspects it contains, such as reciprocated support and love, were often cited as the predominant reasons for reducing together.

If in treatment, it appears that attempts to reduce or stop opiate use within the relationship can be difficult if one member of the relationship either relapses or continues to use. This is consistent with the literature about partner influences on relapse in drug users (Sun, 2007; Notley et al., 2013). Relationship compatibility theories suggest that relationship satisfaction is positively correlated in couples who share similar characteristics and behaviours (Cox, Ketner & Blow, 2013), supported by Fals-Stewart, Birchler and O'Farrell's (1999) suggestion that couples with concordant drug use patterns associate their use with

positive relationship satisfaction. Again, attachment theory offers theoretical insight into the difficulties associated with opiate reduction in relationships, positing that addiction within couples can be viewed as an attachment problem, in which substance use is connected with masking pre-existing attachment difficulties (Fletcher, Nutton & Brend, 2014). Attachment research has found that avoidant attachment styles are linked with problems with addiction (Piehler et al. 2012), and that substance use can be viewed as an attempt to self-regulate (Padykula & Conklin, 2010). Flores (2006) explained that substance use can create a feeling of a secure base and become a potential substitute for interpersonal relationships or protecting the individual from relational vulnerability. From this attachment perspective, it is argued that couples should be supported to develop healthy attachments within the relationship as an alternative to drug use (Landau-North, Johnson & Dalgleish, 2011). Disruptions in the shared relationship behaviours, and potential activating attachment difficulties, typically regulated through joint opiate use, may explain some of the difficulties expressed within this review of individual attempts to reduce or stop opiate use without both members of the couple engaging in that process.

Motivational interviewing (MI) has been widely adopted as a therapeutic approach in promoting behavioural change, most notably in alcohol and substance use (Rollnick & Miller, 1995 & Miller & Rollnick, 2012). It has been suggested that Self-Determination Theory (SDT) offers a theoretical framework for MI (Markland, Ryan, Tobin & Rollnick, 2005). Within SDT, the social environment is specified as key in facilitating motivation to change one's behaviour, with the need to have supportive social and intimate relationships and to feel connected (Baumeister & Leary, 1995). This may offer some explanation as to the complicated dynamics in recovery found here, where some relationships have a destabilising effect on treatment whilst others promote recovery through mutual support. Furthermore, systemic theories of addiction such as the Social Ecology (Adams, 2008) and stress-strain-

coping-support (SSCS) models (Orford et al., 2013), promote a social paradigm of addiction, positing that identity is primarily social and that social connections facilitate and maintain one's own identity. Both these models highlight how close relationships influence the maintenance of addiction, emphasising the importance of interventions that include family and significant others in treatment (Selbeek, Sagvaag & Fauske, 2015).

Exploring gender dynamics highlighted how couples would typically arrange into some traditional gendered roles, reflected also in relation to opiate use, with males often taking the role of provider within the relationship, whether this was related to drugs and its use or to other aspects such as financial. Social role theory offers a biosocial understanding of how gender roles are internalised and expressed within a cultural context (Eagly & Wood, 2012) postulating that a division in labour between genders is influenced partially by the social context. Such gender specific roles are acquired through socialisation in childhood and developed through adolescence and adulthood (Miller et al., 2006). It could be theorised, from the accounts provided in the review, that the provider role is adopted by more males because these roles predominately require dominant or resource gaining behaviours, seen as stereotypical of the male gender role (Eagly & Wood, 2012).

Power imbalances were apparent within the synthesised literature, with males often described as exerting control over females within relationships, the most extreme examples involving coercion, economic, psychological and physical abuse. Brookoff (1996) has highlighted the influence of drugs and alcohol on domestic violence, with a high proportion of victims and perpetrators using substances and these findings seem consistent with the findings of this review.

The studies in this review feature individuals from a wide range of cultures and countries, including Australia, Canada, Ghana, Indonesia, Thailand, Mexico, UK and USA. The variety of cultures offer diverse accounts, which is a strength of this review; however,

this may conflate a number of culturally specific issues such as gender specific roles within cultural contexts. In the spirit of reflexivity, the first author (PW) was aware of his experience as a white, heterosexual male, residing in a western culture, who has worked previously with individuals with drug use difficulties. This enabled the author to consider how they interacted with the data, particularly using an outsider perspective, to understand and build his own knowledge of cross-cultural diversity of couples who use opiates.

Difficulties were experienced in the search for appropriate qualitative studies, which is acknowledged as a problem researchers may face in conducting qualitative syntheses (Atkins et al., 2008). Unclear descriptions in the abstracts and keywords of studies make study selection difficult (Shaw et al., 2004) and made it a challenge for this review to apply a targeted search strategy. The initial database searches resulted in a high number of inappropriate studies identified in the screening phase. Conversely, the review search strategy was extensive but appropriate research may still have been overlooked due to the poor indexing of qualitative research. As not all qualitative, or mixed methods studies apply methodology keywords to the study index, it would be useful for editors and researchers conducting such methods to explicitly apply these to the key word strings, to assist researchers in synthesising literature. However, despite the large number of papers screened at the title and abstract phase, the number of included studies within the synthesis is in line with the findings of France et al. (2014) who found that meta-ethnographies included an average of 21 papers, ranging between 3 and 77. Nevertheless, the large scale of the initial title and abstract screen alongside a 25% screen by a secondary researcher could still be viewed as a potential weakness of this current systematic review.

The lead researcher conducted the initial title and abstract screen of the studies extracted from each database and a 25% sample was screened by a secondary screener (JG). A further collaborator (LM) was involved in the later stage of study selection from the full

text screen, being allocated a random 20% sample of the studies, to explore inter-rater reliability. On reflection, a secondary researcher could have been involved in the complete title and abstract screening phase. Due to time constraints, a complete additional title and abstract screen could not be conducted.

The critical appraisal of studies within a qualitative synthesis can be problematic and current tools for qualitative critical appraisal are difficult to apply. It is challenging to compare the quality of studies that use differing study designs and analyses, with tools not providing an in-depth understanding of the methodological issues evident within each study. All studies were included within the review, despite their rating on the CASP, with some scoring significantly lower than others, to allow the inclusion of verbatim individual experiences from the study findings. Furthermore, author interpretations were included, some in the context of low scoring CASP ratings, particularly on study methodology and analysis components.

In terms of entering and adhering to drug use treatment and other health related treatment (i.e. HCV or HIV), individual motives for the relationship and key positive aspects of these relationships should be recognised, and benefits acknowledged. Healthcare services could consider outreach programmes aimed specifically towards opiate using couples or offering couples-based treatment pathways such as Behavioural Couples Therapy (BCT). Schumm et al. (2012) found that BCT was equally effective for alcohol using couples, compared with treatment that supported a couple where one member of the couple was alcohol dependent. Braitman and Kelley (2016) suggest that BCT for drug using or alcohol dependent couples is equally viable as BCT for single partner substance abuse.

Additionally, it must also be recognised when the relationship may be detrimental to the individuals within them, most notably in the prevalence of interpersonal abuse and control. This is a significant consideration for health care services who are in contact with

individuals, highlighting the challenges these services face in engaging and supporting them. Implications for treatment should include awareness and screening for domestic abuse within relationships, in line with the National Institute of Health and Care Excellence (NICE) published guidance for how health and social care services should identify and reduce domestic abuse (NICE, 2016).

Future research could seek to understand relationship experiences of couples who use other drugs or alcohol. As poly-drug use was prevalent in the reviewed studies, this could be a focus of further research. The research couple demographic was typically heterosexual. There is a gap in understanding non-heterosexual relationships, which may shed light on unique relationship dynamics not referenced in the heterosexual couple opiate use literature.

5. Conclusions

This review has focused on understanding the complex relationship experiences of couples who use opiates. It outlines the challenges such couples face in how opiates form a significant foundation for their relationships but also how couples define the legitimacy of their relationships through expressions of love, intimacy and care. These aspects are also typically seen in other relationships outside of a drug taking context. This review demonstrates that it is possible to take a more nuanced perspective on these relationships and how relationship dynamics may influence individuals' decisions on opiate use, treatment and managing health needs.

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Chapter 2

Bridging Chapter

Word Count: 269

The systematic review sought to synthesise the literature on opiate using couples, examining the relationship experiences and gender dynamics expressed within these partnerships. The findings of the review suggested a complex interplay of what was termed relationship stabilisers (e.g. love and intimacy, reciprocal care etc) and destabilisers (e.g. conflict, impairment of sexual intimacy), whilst also emphasising the significance of opiate using within the relationship (e.g. bonding through opiate use, joint opiate related activities), and how individuals engage with treatment for their opiate use whilst in these relationships. A diverse range of sources were included in the synthesis across a number of cultures and contexts.

Of interest to drug treatment services and implications for the field of clinical psychology, the review highlighted partner influence on how individuals negotiated their recovery, particularly how intimate partners were a strong influence in reported relapse but could also be an influence in promoting long term recovery, with some individuals expressing a desire for their relationship to progress from using together to abstinence. As discussed above, this appears to create a dilemma both for individuals engaging in treatment for their opiate use but also for services in how they best support such people.

Given the findings of the review paper, the empirical paper aimed to understand the lived experience of people who are in treatment for opiate use whilst also in relationships with other opiate users, who are themselves not in treatment. The study aimed to build on the systematic review in undertaking a qualitative study in a UK context exploring this particular phenomenon with people engaging with local drug treatment services. The study proposed the question ‘what is the lived experience of being in treatment for opiate use whilst in a relationship with another opiate user’?

Chapter Three

Empirical Paper

"We'll be on different pages, you know" The Lived Experience of Being in an Opiate Using Couple whilst in individual treatment for Opiate Use

This paper has been developed for submission to Drugs: Education, Prevention and Policy. Author Guidelines are outlined in Appendix H. Word count limit 8,000.

Word Count: 8,000

“We’ll be on different pages, you know” The Lived Experience of Being in an Opiate Using Couple whilst in individual treatment for Opiate Use

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Abstract

Introduction: Recent UK statistics for people exiting drug use treatment show that opiate users have the lowest rate of successful treatment completion. Research suggests that intimate partners have a significant motivating role for individuals to engage with drug use treatment and that relationships with other drug users can have a detrimental effect on recovery. There is limited UK research that seeks to understand the experience of being in treatment for opiate use when also in an opiate-using relationship.

Method: The study set out to explore opiate users' lived experience of treatment while maintaining a relationship with another opiate user using qualitative Interpretative Phenomenological Analysis. In-depth interviews were conducted with five participants engaging with drug and alcohol treatment services.

Results: Participants rationalised their relationship, negotiated treatment, referenced identity and re-evaluated their relationship. These findings demonstrate the significant influence these relationships have on opiate users' engagement with treatment and attitudes towards recovery.

Conclusions: Recommendations for further research highlight the need to understand these relationships at a unit level through joint interviews or by exploring the experience of being a partner not in treatment. Implications for clinical practice include the need for approaches that enhance the individual's movement towards meaningful life values, couples-based treatment and approaches to engagement.

Key words: Qualitative, IPA, drug-using couples, opiates, heroin

Introduction

The World Health Organisation (WHO) (2017) defines substance abuse as the harmful use of psychoactive substances including alcohol and illicit drugs, the continued use of which can lead to dependence. The ICD-11 (2018) defines opiate dependence as a disorder of opioid use regulation. Key features are strong drives toward opiate use taking significantly higher priority for the individual over other behaviours that once had value, and persistent use, desire, harm or other negative outcomes. Other features include physical symptoms of dependence such as increased tolerance to opioids or repeated use of opioids or similar substances to alleviate withdrawal symptoms. The use of terms to describe people with such difficulties can be confusing and can have implications for patients in terms of stigma and treatment access as well as policy development (Kelly, 2004; Kelly, Saitz & Wakeman, 2016; Mahmoud, Finnell, Savage, Puskar & Mitchell, 2017). With this considered, the term opiate use and derivatives of this (e.g. opiate user) are used to provide a consist reference towards the people discussed in this study.

Between 2017 and 2018, Public Health England recorded that 268,390 adults (aged 18 and over) were in contact with drug and alcohol treatment services. 141,189 people were in treatment for problems with opiate use, comprising the largest proportion (53%) of the total treatment population (Public Health England, 2018). Successful completion of treatment is determined by clinical judgement and defined by the person no longer needing structured treatment, achieving care plan goals and overcoming dependent use of the drug that required treatment (Public Health England, 2018). The Public Health England (2018) treatment and recovery statistics for clients exiting treatment between 2017-2018 showed that opiate users had the lowest rate of successful treatment completion (26%) compared to other substance misusing groups, citing opiate users as most likely to be chronic drug users, often with ill health and less likely to access personal and social resources linked with recovery. Most

recent estimates of opiate use prevalence in the UK are of 257,476 opiate users, with 23,656 users within the East of England (Hay, Rael Dos Santos & Swithenbank, 2014).

Historically, Public Health England have invested significantly in treatment services (NTA, 2006), with a view to reduce waiting times, improve accessibility, improve the capacity of local drug treatment services, improve partnership working and integrated services. However, more recent cuts to funding and the privatisation of services have resulted in a reconfiguration of treatment service delivery, outlined by the Advisory Council on the Misuse of Drugs (ACMD, 2017). Throughout these changes to service delivery, drug use continues to be shown as a chronic and relapsing problem for those that have been in, and continue to be in treatment, and there is often a pattern of dropping out of and re-engaging with, treatment services over extended periods of time (Bell, Burrell, Indig, & Gilmour, 2006).

Tsogia, Copello and Orford (2001) conducted a systematic review that explored factors associated with problem drug users not entering treatment. They identified social factors, including a lack of social pressure or negative social consequences (i.e. what an individual could lose socially from entering treatment), as important influences in an individual's motivation to engage with treatment, alongside other variables such as demographic characteristics, health and substance related problems, intra-psychic difficulties; life events and prior treatment experience. This review also highlighted that qualitative research into the social relationships of drug users was limited and that the user perspective had not been adequately considered. Following this, Notley, Maskrey and Holland (2012) explored the perceived barriers to treatment engagement of problem drug users not currently in treatment, confirming that these tend to fall into three categories, interpersonal, social and system barriers.

The literature exploring the involvement of non-drug using family members and partners, suggest that they support problem drug users in many aspects of treatment. Evidence from behavioural, community reinforcement and family approaches, show that involvement of abstinent family members or carers, can lead to improved treatment outcomes (Stanton and Todd, 1983; Stanton and Shadish, 1997). Family- based engagement strategies have also been shown to make a significant difference in the treatment engagement rates of adolescent drug users (Liddle, 2004). More recent research supports the notion that family involvement in a drug user's treatment journey can have a positive effect, including in facilitating entry into treatment, retention and reducing dropout. It is also associated with more positive outcomes in terms of reduced drug use and progression to abstinence, and reduced social problems (i.e. legal, family, employment and violence problems) (Copello, Velleman & Templeton, 2005). When compared with other treatment interventions, family-based treatments have also demonstrated more positive outcomes, including reduced problem drug use, improved treatment engagement and retention (Liddle, 2004).

Public Health England defines recovery as achieving abstinence from drug dependency and having achieved goals in making positive changes in their lives (i.e. whether they have found employment, suitable housing and whether family relationships are functional) (Public Health England, 2018). Public Health England policy has also recognised the significance of the social context of a problem drug user's recovery, emphasising that partnership arrangements for supporting the families are often required (Public Health England, 2018) and that family members should have active roles in a problem drug user's treatment if possible (Department of Health, 2017).

However, the drug use behaviour of members of one's social group can influence an individual's treatment engagement and outcomes (Hawkins & Fraser 1989; Knight & Simpson, 1996). Research exploring relationships in which both parties in a relationship are

using drugs, referred to in the literature as drug using couples, has shed light on the complex interaction of intimate relationships and problem drug use. Amaro and Hardy-Fanta (1994) argue that close intimate relationships with other drug users can have a detrimental effect on recovery from drug misuse. Furthermore, it has been suggested that intimate partners who use drugs have a significant role in limiting the motivation of their partners to engage with drug use treatment and reduction, proposing that greater independence from a drug-using partner could allow individuals to recognise, consider and confront their own drug use, and to be less influenced by their partners' continued drug use (Riehman, Hser & Zeller, 2000).

Fals-Stewart, Birchler and O'Farrell (1999) explored these associations between the drug use behaviours within relationships, relationship stability and treatment efficacy. During and after treatment for drug use, they examined the relationship adjustment and changes in drug use between drug-using couples and couples where only one person in the relationship met the criteria for substance abuse or dependence. The findings showed that relationship satisfaction was negatively associated with drug use in couples with one drug-using partner, compared with a weaker association in drug- using couples. Treatment engagement of drug-using couples led to increased relationship instability, which was positively correlated with time abstinence from drugs. This contrasted with the findings for couples with one drug-using partner, where relationship instability reduced during treatment and there was extended drug abstinence. Furthermore, during treatment and at one year follow- up, drug use was more frequent in individuals whose partner also used drugs. Fals-Stewart et al. (1999) posited that the findings from this study support the notion that relationship satisfaction and stability is positively associated with drug use in drug-using couples because shared drug use becomes an important recreational activity within the relationship.

In the literature, intimate relationships between drug users are often conceptualised in negative terms, relating to domestic violence, abuse and coercion (Farris & Fenaughty,

2002), which is reflected in Narcotics Anonymous groups and other drug treatment groups discouraging relationships between members (Stevenson & Neale, 2012). However, some research has suggested that intimate relationships between drug users can also have a positive influence on drug users' lives, particularly in enabling them to manage their drug dependence and to reduce their overall drug use (Simmons & Singer, 2006; Tucker et al., 2005). Although it has been shown that amongst heroin using couples, greater decision-making power has been associated with increased abstinence (Riehman, Iguchi, Zeller, & Morral 2003), further research in relationship dynamics is clearly required, since the interactions are complex and not linear.

The impact of couple relationships in drug use treatment appears to be an important factor in influencing engagement and recovery outcomes. Yet there is limited qualitative research, in a UK context, exploring the experience of problem drug users engaging with treatment services whilst within a drug- using relationship. As opiate users comprise the highest proportion of clients in treatment, yet proved the lowest in successful treatment outcomes, it is particularly pertinent to explore this question in the context of opiate users who are accessing treatment and support. In depth, qualitative research within this population can make an important contribution to current understanding of the issues within opiate- using relationships and could shed light on the experiences within such relationships that may impact on the individual and on treatment and recovery.

Method

Design

This was a qualitative study using Interpretative Phenomenological Analysis (IPA). Compared with other qualitative methods such as grounded theory and discourse analysis, the key difference between these and IPA is epistemological in nature. Grounded theory is

focussed on generating theory through identifying social process, whilst discourse analysis is concerned with how events of reality are constructed through language (Starks & Brown Trinidad, 2007). The rationale for using an IPA approach was to gain a deep understanding of the lived experience of the participants and their relationships. IPA is based on phenomenological epistemology (Smith, Jarman & Osborn, 1999), which explores the subjective experience of the individual rather than defining an objective reality. Smith (2004) describes IPA as idiographic, placing emphasis on a detailed, nuanced and in-depth analysis of each participant case (Smith, Flowers & Larkin, 2009), suggesting that in order to gather the rich, detailed, experiential data necessary for analysis, a small purposive sample is preferable to a large number of interviews. The method also acknowledges the researcher's interpretation of the participants' interpretations, known as the 'double hermeneutic' process (Smith et al., 2009). To facilitate this process, a reflexive diary was kept by the first researcher throughout the research project to record their assumptions and experiences throughout the research process and reflective accounts of interviews. These methods allow researcher beliefs and conceptions to be bracketed during the data analysis (Smith et al., 2009).

Ethical Considerations

During the research project, the recruiting substance misuse services were re-tendered to a third sector provider. Therefore, following ethical approval from the Cambridgeshire Research Ethics Committee (REC reference: 18/EE/0037) (Appendix I) and the Health Research Authority (HRA) (Appendix J), further ethical approval was sought through the Faculty Research Ethics Committee at the University of East Anglia (UEA FMH reference: 2017/18 – 121) (Appendix K) and for service names changes on documents (Appendix N). An amendment was made to the recruitment process, which was approved by REC

(Appendix L), HRA (Appendix M) and UEA FMH (Appendix O), allowing participants to be interviewed at home to reduce participant burden.

Participants

Five participants (Table 1) were purposively recruited through advertising, using posters across clinic site waiting rooms and the involvement of key workers within services to screen and identify participants. All participants were engaging in Opioid Substitution Treatment, predominantly Methadone, with one participant currently using Buprenorphine prescriptions. All participants were regularly meeting with their allocated key workers in East of England drug and alcohol treatment services.

Recruitment

Purposive sampling was used, a method that allows the researcher to identify and select individuals that are experiencing the phenomenon of interest (Etikan, Musa, & Alkassim, 2016) and for this purpose, is viewed as an appropriate method of sampling in qualitative research (Patton, 2002).

The study recruited problem opiate users currently engaging with treatment services within East of England. The inclusion criteria were as follows: participants aged 18 and over, in contact with and receiving treatment from services for opiate drug use and married or in an enduring close personal relationship of at least 12-month duration with another opiate misuser who is not in contact with treatment services. Participants who were unable to provide informed consent to participation, or where problem alcohol use or drugs other than opiates were the primary substance focus of treatment, were excluded.

Procedure

Prior to the research interview, participants completed a brief demographic questionnaire (Appendix P).

All interviews were conducted by the first author, face to face either in treatment clinics or in clients' own homes. Semi-structured interviews typically lasted 60 minutes and followed a semi-structured interview format using a pre-formulated topic guide (Appendix Q) exploring past and current opiate use, drug treatment and relationship experiences. Given the potentially emotive content of the interviews, participants were given time to discuss the nature of the interview with the researcher, and debriefing information was provided at the end of the interview (Appendix R).

Interviews were digitally recorded and additional reflective notes on the interview process made by the researcher, directly after the interview, to support the analysis. Following this, interviews were transcribed by the primary researcher verbatim, ensuring to note all remarks, hesitations and pauses (see Appendix Y for an example).

Analysis

An IPA approach towards the data analysis, following the methodology proposed by Smith et al. (2009), was followed. IPA seeks to understand the individual's experience and understanding of their personal world through the researcher facilitating the emergence of phenomena and in turn making sense of it. The developing understanding of the participants' narrative is gained through the researcher examining the accounts reflexively, acknowledging the researcher's own conceptions and perspectives. Smith and Osborn (2003) describe this as a double hermeneutic process, where the participants are trying to make sense of their world and the researcher is trying to make sense of the participants trying to make sense of their world. Importance is therefore placed on the researcher's awareness of their own perspective, knowledge and attitudes that they may bring to the topic (Smith et al., 2009).

The method is idiographic, in that an in-depth exploration of a single case is pursued until a level of closure can be achieved, before moving to an analysis of a second case and so on (Smith, 2004). IPA is concerned with understanding the individual and an in-depth analysis

of a single case aims to provide detailed, nuanced analyses of specific instances of their experience (Smith et al., 2009). Smith and Osborn's (2003) proposed steps for the analysis, outlining a pragmatic approach, were followed during the interview analysis. This involved initially looking for themes within the first case, then a stage of a more analytical ordering, as a sense of the connections between emerging themes is made, finally continuing the analysis with other cases. In the following stage of analysis, an iterative approach was followed, returning to interview transcripts to ensure that themes were not missed. Cross case analysis was then conducted to capture patterns across themes and then clustered to form superordinate themes (Smith & Osborn, 2003; Smith et al. 2009). Developing themes were discussed in research meetings between PW and CN.

Results

Participant characteristics are summarised in Table 1. All participants interviewed were currently engaging in Opiate Substitution Treatment (OST), most were prescribed methadone, whilst one participant was prescribed buprenorphine. All participants were in OST for heroin use and all partners were active heroin users. Relationship duration varied between 2.5 years and 5 years.

Table 1 - Participant & Relationship Demographics

Participant Number & Pseudonym	**Age**	**Opiate use in treatment for**	**Current Treatment Provided**	**Duration of relationship (years)**	**Nature of relationship**	**Main substances used by partner**
1. Vicky	45	Heroin	Buprenorphine	2.5	Engaged	Heroin / Alcohol
2. Sarah	39	Heroin	Methadone	3	Co-habiting	Heroin/Crack cocaine
3. Tom	55	Heroin	Methadone	5.5	Married	Heroin
4. Kate	37	Heroin	Methadone	5	Married	Heroin
5. Yvonne	48	Heroin	Methadone	3	Co-habiting	Heroin

The interviews were analysed, with four superordinate and nine subordinate themes emerging, presented in Table 2.

Table 2 - Superordinate and Subordinate Themes

Superordinate theme	**Subordinate theme**
Rationalising the relationship	Romanticising Uniqueness of Us
Negotiating treatment	Partner influence Formulating Recovery
Identity dissonance	Identify shift Self as addict
Re-evaluating the relationship	Differing directions Relationship Discord

Superordinate themes were defined as ‘Rationalising the relationship’, ‘Negotiating treatment’, ‘Identity dissonance’, and ‘Re-evaluating the relationship’. Quotation sources are provided at the end of the quote using a pseudonym from Table 1.

Rationalising the relationship

This theme encapsulates the participants’ descriptions of how they experienced and defined their relationship with their partner. Participants described their relationship often by comparing them with previous relationship experiences, typifying their current relationship in terms of better quality, emphasising romanticism and uniqueness.

Romanticising

When participants defined their relationships, they typically framed them in an idealised way or promoted the more positive aspects of their relationships “*it has its ups and downs. It’s strong, happy, loving, like I said it has its ups and downs, but yeah good.”* (Kate), “*On the streets, we met with nothing. Which is the best way to meet because there’s none of this, Oh look at my big house, my car, my big bank account (laughs).*” (Vicky). One participant, Yvonne, described how she viewed her partner as a *“real gentleman”* and being “*very similar to me in values*” as a rationale for how they bonded as a couple:

“He was a real gentleman compared to everyone else. […] I’ve always been someone who is old fashioned in what I believe you know, you don’t sleep with someone before you get with them, things like that. That’s what stood out for me about him, he was very similar to me in values, he had the same values as me (Interviewer: Yeah) so that’s why I think I bonded with him.”

(Yvonne)

The meanings drawn from their descriptions can be seen as rationalising or justifying their relationship through a prism of romanticising in the context of drug use and hardship. For a number of participants, their experience of past relationships, usually with other heroin users, had often been violent. They drew comparisons with their previous relationships by venerating their current partners "*I've actually got someone who would never touch me, that I haven't gotta be scared of him. Which is brilliant (laughs)*" (Vicky). For Kate, while her previous partners had been both physically violent towards her and had initiated her to drugs, her current partner offered her a quality of relationship that she had not experienced before, "I*t was nice because I'd just, I'd had two like abusive relationships […] the first one got me taking crack, and the second one got me injecting heroin. (Interviewer: Ok) and erm, on the game so it was quite nice, quite refreshing to be in a, er, nice relationship*." (Kate)

In contrast to other participants, Sarah's account diverges somewhat from romanticising of the relationship, instead describing the relationship as being more platonic and friendship-like and centred on functionality. "*We've got a very good friendship. He's actually wonderful to me, he does all the cooking all the washing everything. So I don't have to do anything, you know I do help now and again.*" She identifies her current partner and the relationship as a site of protection from other male interest. From her account of losing her previous partner, there appears to be a difference in the quality of her current relationship and her belief in its less romantic nature:

"I'd just lost (ex-partner) and he was, I'll be honest, he was the love of my life and urm it was a big shock to me and when I met [partner], I needed a friend because I had a lot of blokes, (mimics) 'O she's free now' trying it on with me and I didn't need that. I just needed a friend and he stood by me."

(Sarah)

Uniqueness of Us

When participants spoke of how their relationships were formed and maintained, they described the relationship as being unique or special in some way. Some participants drew comparisons between their relationship and those of other drug users. For example, Tom noted that he felt it unusual that his relationship survived in the "*society of addicts*":

"We're a very strong couple, it's unusual in this sort of small percentage of society of addicts, it's very usual for people to stay together."

(Tom)

Yvonne's comments go further in an explanation of this perceived difference; in her perception, her relationship is "*more than drugs"* in that other drug- using relationships are centred solely on drug use. Here, positioning the 'other' type of relationship first before describing the relationship sets up the 'bad relationship' in contrast to the 'good relationship' described and experienced. Yvonne gives this as a reason for her to remain with her partner:

"I do think that like with a lot of addicts, […] the relationship is built solely upon that the drugs, so if you took the drugs away then you've got two people you have got nothing in common, they've no similarities, they don't share any interests, it's solely drugs and the need and sometimes the greed for them. […] but I do know that with [partner] and I there is more than drugs, I do know that, […] I couldn't just leave him."

(Yvonne)

Others reflected on how their relationship was born from, and developed through, shared adversity, creating an idiosyncratic relationship. For example, having recently secured

housing, Vicky described the homelessness she had shared with her partner, articulating a feeling of how this fostered their relationship, "*It's been good, like I say we both started with nothing, we were both on the streets so we built ourselves up.*"

Negotiating Treatment

Participants' accounts of their experiences of treatment often highlighted some of the dilemmas faced in the relationship in terms of influences on negotiating treatment and of shifts in identity associated with changing their relationship with opiates. These were named in the context of initiating treatment but also in maintenance and attempted opiate reduction.

Partner Influence

Participants expressed how their relationship interacted with and impacted on their treatment for opiate use. Both Vicky and Yvonne experienced pressure from their partners to enter treatment for their opiate use, despite their partners not being engaged with treatment themselves. Vicky notes the irony of her partner placing an ultimatum on the relationship for her to enter treatment for her opiate use:

"*I liked the buzz of it (Interviewer: OK) and then actually [partner] put his foot down […] (Interviewer: Put his foot down?) Yeah, and he just got pissed off with me doing it and he didn't like sitting there watching me inject (Interviewer: OK) and he said (laughs) it's a bit ironic but he umm basically gave me the, the ultimatum, you stop or we're over.*"

(Vicky)

Vicky rationalises the intention behind her partner's ultimatum as an attempt to prevent her following a similar path of opiate use to his "*He didn't want me going down the*

same road as him (Interviewer: OK) He's been a addict for, I'd say, about 20 years.". Yvonne offers a similar account of her partner influencing her decision to enter treatment but holds opposing views of her partner's intentions behind his support, one of unconditional support and care and another of her progress enabling him to continue his opiate use unchanged, suggesting an underlying mistrust in his motives:

"*He wants me to give a clean sample. But I think sometimes, he'll say 'you're not having any of this, you've got to give a clean sample and that'll look really good, I'm really pleased' and I think, one minute I think yeah he's supporting me but then a part of my, something creeps in and I'll think he's only saying that because he doesn't want to share it.*"

(Yvonne)

All participants identified their partners' continued use of opiates as a key factor in their difficulties in reducing their own drug use in terms of shared enjoyment: "*I do enjoy a smoke with him, it's like someone having a glass of wine at the end of the day, that's the way I look at it because I've done it for so long, it's something that we enjoy.*" (Sarah). There was also intentional collusion to use: "*you know what the term setting each other up means? You, sort of, you know, say erm, I'm doing well and I might see [partner] have something and it might make me think about having something […]. I'm painfully aware of that sort of thing.*" (Tom), "*you can be triggers for each other*' (Kate). The proximity of their partner when they use drugs was cited as a trigger for relapse: "*I don't really think about the heroin other than when I see [partner] injecting.*" (Yvonne)

Formulating Recovery

Within their treatment journey, participants outlined their idiosyncratic beliefs around the workability of continued opiate reduction and what constitutes recovery for them. A majority of the participants expressed their intentions to work towards and achieve abstinence as part of their current treatment. Tom highlighted the cyclic nature of his addiction: "*I've been clean before and then sort of relapsed, but it's always my goal to be totally clean"* He also formulated his recovery in other ways, identifying meaningful changes that being on methadone maintenance had enabled him to make, such as maintaining employment and reducing criminality:

"you can sort of manage your life, I'm holding a job down now, that's the main thing really. It helps you get your life in order […], there's going to be a point when I want to get off that you know, that's what it does. […] the big thing is that it took crime out of it"

(Tom)

There are parallels with Kate's experience who identifies engaging in employment and training as positively influencing her recovery journey, whilst also outlining her goal of abstinence:

"*I'm quite happy where I am at the minute because I'm steady, I'm doing really well at the moment. I'm working, I'm doing some more training at the moment with the company next week and erm, so but eventually I'd like to be off everything."*

(Kate)

However, others made sense of their recovery differently. Sarah described her motivation for being in treatment for her opiate use: "*I wanted to be in service, I wanted to sort myself out*" but also reflected on her enjoyment of using, and her struggle to see her future without heroin:

"I'd love to say you know, I'm never going to do it again but I'd be lying you know, I enjoy it, I enjoy once every couple of months or once a month I enjoy spending a little bit of money and I enjoy doing it. I think I'll always be like that, but I can't see at the moment, it's me getting over the I enjoy doing it bit."

(Sarah)

Sarah rationalised this by referring to the limited repertoire of other important experiences in her life outside of heroin use, which further undermined her determination to reduce her heroin use.

"*I think I'll always be like that, but I can't see at the moment, it's me getting over the I enjoy doing it bit, I think. (Interviewer: Yeah) If I had other things going on in my life which I'm struggling at the moment to.*"

What these accounts show is that recovery is viewed not just in terms of reduction in opiate use, alongside titration of opiate substitutes, but also in terms of individual values and meaningful life goals.

Identity Dissonance

The impact of engaging with treatment for their opiate use leads to participants experiencing a conflict in self-identity. There appears to be a shift in perception of who they are and the new roles they take on in their life, whilst also accommodating an enduring identity of an *addict.* These new identities are often carefully negotiated within long-lasting social environments which juxtapose this identity shift.

Identify shift

Participants experienced a change in the perception of who they are and the values of their life. For some, this was not a straightforward process. In the context of treatment and recovery, gaining insight into the cost of their relationship with opiates could be distressing, with a sense of loss and negative self-image becoming apparent. Now in recovery, Kate noted the detrimental impact her heroin use had had on her life and familial relationships:

"You waste your money, you feel rubbish about yourself, you feel dirty, guilty, ashamed. And you sort of tend to isolate yourself from people, you feel that everyone knows, even though they probably don't (laughs). I hate it. It's taken so many years of my life you know, I wasted so many years that I could have had a relationship with my mum so, my brothers because of it. I could never get that back and that's all because of heroin. It's just shit (laughs briefly)"

(Kate)

For others, there was an identification with changes in expressing themselves, which had been instrumental in their recovery. As a man, Tom explained that he had come to challenge his previous conceptions of the male stereotype within his engagement with

treatment services, having previously found it difficult, to communicate his emotional world, inconsistent with the "*big strong one taking everything on their shoulders*" ideal:

"*I've learnt that I can't always do that. I need to share it a bit. It's just that sort of macho, stereotype type, caveman type (laughs) that been around for years and I try not to be like that."*

(Tom)

Others who were still using heroin whilst in treatment also noted a difference in identity. Vicky viewed herself as different or better than other heroin users in her treatment service: "*it sounds really bitchy but I was looking at other people who were doing it and thought (laughs) you scum bags, I'm better than you.*" Being in treatment and having access to harm reduction apparatus allowed her to vindicate her continued heroin use as more principled than others, enabling her to develop a sense of moving away from a perceived identity as the worst drug user or "*dirty junkies*". This had the consequential impact of vilifying the other group in order to bolster her own self-esteem:

"*You know if I do it, I do it indoors and I use a sin bin, don't want to leave it on the street, cos I've been there with my kid in the park and there's been a dirty needle on the floor and anyone could fall over and jab themselves, that's where people get the dirty junkies.*"

(Vicky)

For Vicky, this appears not as a full shift in identity in the sense of recovery or abstinence, but more a 'moving up' in a perceived drug user hierarchy, offering some ego or identity protection.

Self as addict

Participants described a number of ways in which they were wedded to a sense of being an addict or possessing intrinsic traits that represent an addictive nature. All participants described using heroin for a number of years. Many also used and for some the use of other drugs or alcohol prior or alongside their heroin use, influenced their view of themselves as an addict:

I've always had an addictive personality, […] I was addicted to speed for years. […] then I was only smoking gear on the pipe and then started injecting and the buzz was better (Interviewer: OK) and then you start having snowballs, which is with the crack, and wow (laughs)."

(Vicky)

Additionally, some participants described the pleasure they derived from using opiates whilst working towards opiate reduction or long term abstinence, which appeared to reinforce their view of being an addict: "*But then that is just crazy because I'm in treatment and I'm stable and, but that's just insane thoughts, it's, that's what being an addict is.*" (Yvonne). Others viewed the challenges of opiate reduction in light of their sense of an addict identity: "*Erm well, I'm just not, I knew it wouldn't lead to sort of like happiness you know, it wasn't going to benefit me, but I'm an addict so it was hard."* (Tom).

Re-evaluating the Relationship

Differing Directions

Within their accounts, participants often spoke of the impact of treatment and their engagement with opiate reduction on their relationship, leading to re-appraisals of the longevity or stability of the relationship. Once drawing commonality within the relationship, participants became aware of the difference in life trajectories that they and their partner could potentially take in light of their heroin reduction. Yvonne expressed pessimism regarding her relationship lasting if her partner continued to use: "*we'll be on different pages, you know*", worrying that it would endanger her own recovery:

"*It'll be really hard to stay together because we'll be going in different directions, and it's (exhale of breath) if I'm clean and doing well I won't want him using, […], it would be putting my recovery in jeopardy.*"

(Yvonne)

Sarah described how her partner had begun to express feelings of insecurity in their relationship. She acknowledged their current incompatibility "*We're not very compatible at the minute*", and rationalised the reduction in their intimacy as a couple to her preoccupation with heroin reduction:

"*our intimacy at the moment isn't very good, that's the main part what isn't very good (Interviewer: Okay) but I'm not too worried and I know that sounds bad but I'm not really too worried about it. It's not something, because I've had so much on my mind with coming off the gear, you know and my using down.*"

(Sarah)

Interviews highlighted a divergence in how these individuals were relating with their partners but also their attitudes towards the relationship's future. Attempting to reduce heroin use provided participants with an alternative focus to the relationship, whilst also fostering an explicit split in aspirations for the future between the partners. So, it can be understood that treatment disrupts not only the harmful nature of opiate use, but also the protective nature of the relationship, or at least the way the relationship is viewed. This is a real double-edged sword when it comes to thinking about what means more to individuals - being clean or the safety of the relationship.

Relationship Discord

During their engagement with treatment, participants often expressed their frustration at their partner for not doing similarly, whilst also noting their own powerlessness in influencing them to do so. Vicky's account offers an example of the imbalance in these relationships, having noted her partners "*ultimatum"* to enter treatment but feeling unable to reciprocate a similar stance:

"*it's frustrating and I want him to get into treatment and oh my god how many times he's said, yep yeah I'll come, yeah I'll come in, and he don't, but like that's hard because he gave me the ultimatum and I done it (pauses) but I can't give him the ultimatum back."*

(Vicky)

Conflict is also experienced in relation to opiate use. Whilst the participants obtained maintenance scripts for opiates, their partners continued to use heroin to manage withdrawal. Sarah spoke of arguments with her partner, particularly in the morning when her partner

started to experience withdrawal symptoms: "*He might get a bit shitty with me in the morning because of how he's feeling, and I'll be alright because I've got enough methadone*". Vicky explained her arguments with her partner as around obtaining and continuing to use heroin, with his perception that he no longer needed to share the heroin they obtained as she was on a script:

"*at times obviously when we're skint and struggling for money to get it, and then he's a bit, (imitates partner voice) 'oh you're alright because you've got your script', you don't need it, here you are you've got your script, well ok you can have a script, you've just got to get up off your arse and get it."*

(Vicky)

Conversely, other participants emphasized the harmony within their relationships, and the minimal conflict in comparison to previous relationships. Kate spoke of the unconditional support she received from her partner, and made no reference to any discord in their relationship. Having been in successive abusive relationships, she underlined her partner's attempts to support her emotionally:

"He's always been really supportive in lots of ways. And I had my confidence battered by previous partners and he's built up my confidence again in lots of ways, in myself, in believing that I can work that I'm worthy of working and that I'm a worthy person. It's definitely helped my self-confidence massively."

(Kate)

Discussion

Participants described a series of pertinent and difficult experiences to both their opiate treatment experience and relationship with another opiate user. Formulating their relationship through a prism of romanticism and uniqueness allows the participants to justify its continuation and difference from other drug-using couples, externalising the difficulties the couples face, creating a sense of stability and functionality of the relationship unit.

Participants face a challenge to their sense of identity, with a gradual shift toward a 'drug free identity' or hope of attaining new experiences outside the drug -using world. However, participants also hold a self-concept of being an addict, viewing themselves as having addictive traits or innate characteristics that explain their opiate use, which could create potential difficulties in reducing opiates.

Whilst in treatment for opiate use, negotiating opiate reduction with respect to their partner's continued opiate use causes risk of and actual relapses in participants' attempts to reduce. Participants' own beliefs and idiosyncratic attitudes towards recovery also influenced their treatment journey. Conversely, treatment could also disrupt the view of the relationship, creating a divide, making individuals question the relationship itself. This presents the individual with a challenge between recovery and maintaining the relationship status quo. Continued work towards opiate reduction can further foster a divergence in the couple relationship, with most participants highlighting a desire to work towards long term recovery from drug use, despite the absence of their partner's own reduction attempts. This drug use discrepancy within the relationship can lead to some pessimism over the relationship lasting if the partner were not to change their own drug use. Some participants mediated this relationship instability somewhat by continued engagement with drug use with their partner whilst on their maintenance scripts, thus negating the desire for their partner to enact their own change. Relationship discord, manifesting as frustration and arguments, was exacerbated

by the participants' engagement in treatment, and was most evident in the partners' continued attempts to manage their own withdrawal compared with the participants' use of Opioid Substitution Treatment (OST). With these dilemmas or tensions within and across the themes discussed, a more central or core theme of disharmony in the participants' lived experience seems to come to the fore, encapsulating the instability that these people experience both interpersonally and intrapsychically.

In its application, IPA is atheoretical in stance, and is achieved through a reflexive approach to analysis that includes researcher bracketing and reflective diary keeping. With regards to findings, this paper captures the dynamic and complex factors within relationships and treatment engagement of opiate users which relates to theories of identity and motivation. Identity theories suggest that addiction arises from and is in some ways maintained by, parts of one's self-identity. Kearney and O'Sullivan (2003) have explored the role of identity shifts in behaviour change, identifying the sustaining factor in behaviour change as a process of identity revision to consolidate the change and take on a new personal and social self, which in turn leads to further behavioural change. But they also highlight a number of constraints to identity shifts, including social factors such as social pressure to maintain the previous identity and restricted social groups outside of old 'addict' identities. For many drug users this is a pertinent point, with some not having a positive previous self-identity to recovery to. This is reflected in research suggesting that identifying as a drug user becomes an embedded self-concept which makes conceptualising a life without drugs seemingly unrealistic for some (Notley, Blyth, Maskrey, Pinto & Holland, 2015). Self-Affirmation theory (Steele, 1988) posits that behaviour is influenced strongly by the need to maintain self-integrity and identifies self-integrity as being restored by affirming values or other features of self-worth related to one's identity (Harris & Epton, 2009). The findings from this study seem congruent with these theories, as participants appear to enter a process of an identity shift, exhibiting

increased self-awareness and a revision of identity towards long lasting changes. But there are also the challenges of remaining within a social context that can inhibit this shift, through undermining the importance of this change, and maintaining the status quo within their relationship. Additionally, the perceived affirmations of other roles or values that the participants hold, allows them to offset the threats to their self-integrity, promoting objectivity, perspective and resources to confront such challenges to their recovery (Sherman & Cohen, 2006).

The role of identity is not only recognised as important in generating the desire for behavioural change but also has an important place in motivational theory. PRIME theory has been posited as an attempt to synthesis specific theories of motivation of addiction, into a coherent account of a general theory of motivation (West & Brown, 2013). This theory further supports the importance of identity in the motivational system, considering the role of identity as a significant factor in generating desires to enact and maintain behavioural change. Findings supporting this aspect of the motivation towards sustained behaviour change are most notable in the smoking cessation literature (see for example, Vangeli, Stapleton & West, 2010; Tombor, Shahab, Brown & West, 2013), with the findings of this paper demonstrating a similar importance of identity shift in recovering from opiate use.

Interventions have been developed in line with motivation and behaviour change theories that could offer people with drug use problems support in considering values and moving towards meaningful goals. These include Cognitive Behavioural Therapy (CBT), relapse prevention models (Hendershot, Witkiewitz, George, & Marlatt, 2011) and motivational interviewing (Miller & Rollnick, 2002). The predominant approaches to conceptualising problems with substance dependency here tend to emphasise the individual (Copello & Walsh, 2018), through theories of choice (Becker & Murphy, 1988), compulsion and self-control (Dalley, Everitt & Robbins, 2011) and integrative theories of motivation

(West & Brown, 2013). Limited focus has been placed on the social and systemic influences of substance dependency (Copello & Orford, 2002).The closeness of the participants and those of their partners demonstrated both in typical relationships expressions but also in their drug use, may indicate that supporting the couple relationship as a system, and considering the relationship dynamic may be helpful. The need to consider the couple as a unit when individuals enter treatment for this opiate use may necessitate changes to service level data collection. With respect to family members of people dependent on substances, Orford et al (2013) offer an overview of the Stress-Strain-Coping-Support (SSCS) model, highlighting the social, economic, limited support and ill-health risk of adult family members. However, the focus of a majority of this research is based on abstinent family members in what Orford et al. (2013) describe as a neglected field in itself, further highlighting the limited understanding of non-abstinent relationship experiences and the systemic impact placed on the relationship and the wider social network. Interventions focused on developing social support for reduction in addictive behaviour have been shown to be effective. Social Behavioural and Network Therapy (SBNT) (Copello, Orford, Hodgson, Tober & Barrett, 2002) has been found to be a cost effective and efficacious intervention in the reduction of alcohol use (UKATT Research Team, 2005); in feasibility trials for substance users (Copello, Williamson, Orford & Day, 2006) and with people who are engaging with OST (Day et al., 2013).

Shifts in the relationship could warrant couple-based approaches that consider the role of relationships and the social context within their approach, such as Behavioural Couples' Therapy (BCT). Braitman and Kelley (2016) suggest that BCT for drug using or alcohol dependent couples is equally viable as BCT for single partner substance abuse. However, there are challenges to embedding this type of intervention for people who are using opiates, as there is evidence of some individuals being reluctant to involve partners in their treatment

process (Brooner, King, Kidorf, Schmidt & Bigelow, 1997). Furthermore, it may be important for services to consider recording relationship status and partner's drug use as part of their Minimum Data Set (MDS), to indicate to services any need for assertive outreach to engage a patient's partner in services to optimise the opportunity for both parties to gain from the treatment.. Despite the outlined need for social network-based interventions and it's demonstrated effectiveness, few drug and alcohol services offer these treatments (Copello & Orford, 2002). This may be due to time or resources constraints of services but also a perceived lack of confidence in delivering these interventions due to limited training or supervision (Day et al., 2013). Nevertheless, the findings of this empirical paper reassert the need for the consideration and implementation of approaches that encapsulate systemic and social change.

Limitations of this research should also be acknowledged and how these may affect the validity of the findings. Although strategies were used to recruit a diverse range of people within the inclusion criteria, through a range of recruitment methods, the majority of the interview sample were female, with only one male participant. This is important because Public Health England (2018) stated that of those in treatment for their opiate use, 73% were male. The high proportion of female participants may have illuminated a particular range of gender specific experiences for analysis that a more gender balanced sample could have mediated. Additionally, all participants were white, British and in heterosexual relationships, which may restrict the range of experiences expressed by the sample, although Public Health England (2018) states that 85% of people in opiate treatment were White British and 90% identified as heterosexual. Additionally, accounts of polydrug use were present in some of the participants' interviews, which is a common substance misusing pattern for people using opiates (Public Health, 2018). This could possibly impact the details shared by the participants, particularly in their use of treatment for primarily opiate use.

For IPA studies, Turpin et al., (1997) suggest that British clinical psychology doctoral studies should involve six to eight participants. Although the project set out to recruit six participants, five participants were identified within the recruitment phase, which is still deemed an appropriate number of participants for IPA research (Smith, 2004; Smith & Osborn, 2003). It is recognised that this study recruited from a 'hard to reach' population who are seldom heard within a research context. As this study achieved a small yet appropriate sample size for an IPA study, it should be acknowledged that the findings have shed a light on the experiences of a group not typically captured in research.

Further research could focus on exploring the 'not in treatment' partner's experiences of both their relationship and of opiate use. With shifts in the identity and re-evaluation of the relationship from their partner in treatment, it would be of interest to understand and triangulate this experience from the perspective of the other partner, which may offer insight into their own barriers to treatment and suggest potential approaches for engaging such people in treatment services. If a majority of participants within this research were females in treatment, research on the partner could offer the male perspective. Other potential research avenues could also include interviewing couples together to provide further understanding of the relationship dynamic through couple discourse.

Conclusion

This study illuminates the dilemmas faced by people in a relationship with another opiate user whilst in treatment for opiate use, in terms of opiate reduction, relationship stability and identity change but also highlights the idiosyncratic nature of recovery for opiate users. These relationships highlight a unique challenge for drug and alcohol services in enhancing the care of and support for opiate users and posits the importance of couples-based treatments, assertive outreach for couples, as well as individualised approaches to recovery.

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Chapter 4

Additional Methodology and Design Chapter

Word Count: 3,038

Additional Methodology and Design Chapter

This chapter offers additional information to the methodology and design sections of the empirical study, providing further detail on the qualitative research design and the Interpretative Phenomenological Analysis (IPA) method.

Epistemology and Ontology

The primary research questions of the empirical paper were orientated toward a phenomenological stance in the study's aim to explore participant's sense making of their experiences related to opiate dependency treatment and being in an opiate- using couple. A qualitative paradigm enables researchers to develop an idiographic understanding of people's experiences, related to the research question, and how they make sense of those experiences within their own social reality (Bryman, 1988). This can contribute to the understanding of complex phenomena, offering insights that can inform clinical practice (Boyle, 1991). IPA is orientated towards this position of understanding how people relate to the world and how they take meaning from their experiences within the world (Larkin & Thompson, 2012).

Ethical Considerations

This study was designed and developed in collaboration with a local drug and alcohol service in the East of England. Throughout the development and anticipated recruitment phases, this service was under NHS tender. Therefore, appropriate ethical approval was sought and obtained through the Health Research Authority (HRA) and Cambridgeshire Research Ethics Committee (REC) (REC Reference: 18/EE/0037). However, prior to recruitment starting, this service was re-tendered to a third sector organisation. This required the researchers to seek gate keeper approval with the service provider (Appendix S) and ethical approval through the Faculty Research Ethics Committee at the University of East Anglia (Appendix K). During the recruitment process, further advice was sought with both the HRA and UEA Faculty Research Ethics Committee regarding a proposed amendment to

the research process: to allow for interviews to be conducted within participants' own homes. This was approved as a minor amendment by HRA and REC, and also approved by the UEA Research Ethics Committee Chair.

Recruitment

Recruitment was undertaken using purposive sampling methods. Liaising with key workers was undertaken by the lead researcher and collaborating consultant psychiatrist, to build relationships with professionals who worked closely with the target population. Key workers were given a pro forma (Appendix T) outlining the research study and participant inclusion and exclusion criteria. Posters were also used in the service waiting rooms (Appendix U). However, all participants were recruited from the involvement of key workers who broached the study with the people they supported, providing them with participant information sheets (Appendix V) and consent to contact forms (Appendix W). Following completion of the consent to contact forms, the researcher liaised with the potential participant to arrange an opportunity to meet and undertake the interview if they met the criteria and consented to doing so. It should be noted that key workers broached the study with participants who they felt would be appropriate in terms of criteria but also in terms of level of risk.

Each participant was offered a £20 'Love2Shop' voucher as a reimbursement for their time in taking part in the interview. This voucher was selected as it cannot be used to purchase alcohol or cigarettes. It was explained to the participants that due to financial constraints, only those completing the study would be eligible for the shopping voucher.

Consent

All participants were provided with participant information sheets by their key worker, which allowed a minimum of 24 hours to be read prior to meeting with the researcher, in line with ethical guidelines on providing information to potential participants

and on the consent process. All participants were given further opportunities to discuss the study after meeting with the researcher. If participants were still willing to participate and met the criteria for the study, they were asked to complete a consent form (Appendix X). Participants met with the lead researcher who provided them with an opportunity to ask any questions they had about the study prior to providing consent. They were advised that participation was voluntary, and that they would be able to withdraw their consent to the study at any time up to the point of data analysis. They were informed that their choice to partake in the study or not would not affect their treatment within the service.

All participants who met with the researcher were eligible for the study and consented to taking part in the interview. No participants retrospectively withdrew consent.

Literacy issues were not identified when meeting with the participants but were taken into consideration as a potential issue when ensuring that participants fully understood the study through the participant information form and consent forms. The participant information form was developed and reviewed in collaboration with the volunteer recovery group within the recruitment site service. In addition to this, the researcher checked the participant had read the participant information sheet but also went through the material verbally with them, checking understanding throughout the process.

Confidentiality

Confidentiality of the participants who took part in the study was maintained throughout the research process. An audio recording device was used to record the qualitative interviews. These recordings were transferred electronically onto a password encrypted UEA computer system. Two secure cabinets within the research supervisor's office on the UEA site were available to store participant paperwork. Electronic information (transcriptions, participant log) were kept on a password protected spreadsheet on UEA secure servers after it had been transferred by encrypted memory stick.

Participants were informed that their names and those of others they discussed, including their partner and key workers, would be changed to pseudonyms. Additionally, locations and service names used were also removed to maintain confidentiality. Completed consent to contact forms, consent forms and demographic questionnaires that contained participants' identifiable details were stored separately to interview transcripts containing pseudonyms and other removed details. All audio recordings were permanently deleted following transcription by the lead researcher. In accordance with the sponsor's policy, research data (hard copy and electronic) will be stored for 10 years via standard research archiving arrangements. After 10 years all data will be destroyed. These processes are in line with GDPR requirements.

Interviews and Topic Guide

All participants completed a semi-structured interview using a formulated topic guide (Appendix Q), alongside a brief demographic questionnaire (Appendix P). A semi-structured interview format was chosen as this is seen as a suitable method for IPA research in that it offers flexibility and opportunity to question responses made by the participants (Reid, Flowers, Larkin, 2005).

The initial draft of a topic guide was developed in collaboration with researchers PW and CN. The approach to developing the topic guide involved formulating open- ended questions and ensuring that questions did not make assumptions about the participants' experience (Smith et al., 2009). A first draft was presented to and discussed with a recovery volunteer group from the recruitment site to explore its acceptability for interviews for further development or re-wording of the questions to ensure it captured the essence of the research question. The topic guide was re-drafted using feedback from the volunteer group and used in the interviews.

Each interview was transcribed by the primary researcher (PW). Interviews were transcribed verbatim, using all words spoken by both the interviewer and participant. All utterances, hesitations and pauses were labelled rather than using a verbatim representation.

Analysis

Analysis of the interviews was conducted using Interpretative Phenomenological Analysis (IPA). IPA is a qualitative research method "committed to the examination of how people make sense of their major life experiences" (Smith, Flowers & Larkin, 2009). IPA is seen as one of the most participant- orientated qualitative approaches (Smith et al., 2009), affording researchers the opportunity to explore the lived experience of the research participants they interview (Alase, 2017).

Theoretical Orientation of Interpretative Phenomenological Analysis (IPA)

IPA draws on three principles in its primary goal of examining how people make sense of their experience: phenomenology, hermeneutics and ideography (Pietkiewicz & Smith, 2014).

First conceptualised by Edmund Husserl (1931), phenomenology is concerned with trying to recognise and identify the components that make a phenomenon unique. Smith et al. (2009) describe phenomenological research as systematically and attentively reflecting on lived experience, noting that experience can be first order activity or second order mental and affective responses to experience, and that IPA is concerned always with the subjective experience of "something".

Heidegger (1962) built on the work of Husserl concerning the interpretation of phenomena, acknowledging the need to understand the internal experience of the individual and the language used to express one's experience to then make sense of this message (Freeman, 2008). The analytic process is described as the double hermeneutic, through a

method of the researcher's attempts to make sense of, or derive meaning from, interviewees sense- making of their lived experience of the phenomena (Smith & Osborn, 2008). Within this method, it is acknowledged that the researcher brings their own personal experiences and beliefs. In this regard, Moustakas (1994) advocated for the concept of the researcher bracketing their own personal experiences when attending to the participants' sense-making.

In contrast with the nomothetic approach, which has predominance in psychological research (Smith, Harre & Van Langenhove, 1995), idiography refers to the analysis of the individual perspectives of participants, at a single case level (Pietkiewicz & Smith, 2014), rather than making generalisations about the population (Smith & Osborn, 2008). In this method, researchers make specific statements about individuals rather than generic population driven accounts, as it is based on detailed case examination, moving between significant themes generated and exemplifying them from within individual narratives, comparing and contrasting accounts (Pietkiewicz & Smith, 2014).

Reflexivity

Braun and Clarke (2013) place emphasis on the researcher taking an active role in the research process and in constructing knowledge, with reflexivity seen as an essential requirement for good quality qualitative research (Braun & Clarke, 2013). Reflexivity involves the researcher developing and maintaining an awareness of pre-existing conceptions they have and may bring to bear on the subject of exploration. IPA describes a process of reflexivity within the bracketing approach to the research process (Smith et al., 2009). In the empirical study, the lead researcher (PW) maintained a reflective diary throughout the study design, literature review, ethics approval process, participant interviews and data analysis, so as to adhere to a process of developing a greater awareness of the understandings of the beliefs and assumptions regarding opiate users and their relationships, and how this might

impact on their treatment. An early account from the diary is provided below, outlining the researcher's understanding and experience of opiate users and their relationships:

"I was originally drawn to research within the world of drug dependency because, although I do not have any personal or professional experience with this topic, I have this ongoing curiousity as to why 'addicts' remain 'addicts', even when offered support to change their relationship with drugs. It reminds me of past conversations with friends or family or even on TV, of "why don't they just stop?". It feels like an issue very detached from my life. I come from a small market town in Buckinghamshire and I wouldn't say I knew anyone who has openly had difficulties with drug dependency. I mainly associate heroin users with the inner cities. Drug addicts don't typically tend to be the people that I see on a day to day basis, and even if they were present, I may not even notice they were there. This may also explain the draw for me into this area of research: to shine some sort of light on such a marginalised group of people, even marginalised by me.

At this moment in time, I see people who have a dependency on drugs as perpetually lost and in a constant state of limbo. By this I mean, they may be living each day as it comes rather than looking towards a broader future. My perceptions of opiate users are mainly shaped by the media, which portray opiate users (namely heroin) living in almost destitution, with drug paraphernalia such as used needles scattered over the floor. Their relationships seem intense and based solely around others helping them 'score' or in obtaining money to then buy drugs. The physical impact of withdrawal seems so intense that almost nothing else matters to that person other than their next hit."

Analysis Process

No one single method is outlined for data analysis using IPA (Smith et al., 2009). Instead IPA is characterised by a set of common steps, typically described as an iterative and inductive process (Smith, 2007). Smith et al (2009) provide 'steps to analysis', outlining a

six-step process to the data analysis, which this study followed. The details of each step are outlined as follows:

1. Reading and Re-reading the original data

This initial step requires the researcher to immerse themselves in the original data through repeated readings of the interview transcripts. Smith et al (2009) recommend listening to the audio recording at least once alongside reading the transcript. For the current study, this allowed the researcher to appreciate the utterances, pitch or emphasis placed on words or phrases, which facilitated this process of entering the participant's world.

2. Initial Noting

This involves a process of free note and comment making on the data. This can be conducted at what Smith et al (2009) outline as three levels: descriptive comments on the content of what was said; linguistic comments on the language used by the participants; and conceptual comments that examine the data at a more abstract level. An example of this is provided in Appendix Y.

3. Developing Emergent themes

Through bourgeoning familiarity with the data, the researcher was able to analyse the explanatory comments to begin to identify emerging themes within the transcript. Smith et al (2009) regard this stage as a manifestation of the hermeneutic circle in which the researcher begins to break up the participant experience as the data is re-organised and in developing parts of the narrative that the researcher ties together in terms of mapping connections and patterns.

4. Searching for Connections across emergent themes

Smith et al (2009) outline a non-prescriptive approach to this stage but encourage the development of a means of bringing together the emerging themes and creating a structure that allows one to communicate the poignant and interesting features of the account. For the

current study, the researcher recorded a list of the themes in chronological order, before then moving through a process of reviewing the themes and rearranging them into clusters of associated themes.

5. Moving to the next case

This involves moving analysis to the next participant transcript and repeating the process of steps 1 to 4. Importance is placed on retaining the individuality of the new case by attempting to treat the case in its own right, instead of bringing the influence of the first case analysis onto the second case (Smith et al., 2009). A process of bracketing previous emerging themes and patterns is advised, in line with the philosophy of IPA.

6. Looking for patterns across cases

This stage involves the search for patterns across the interview transcripts, examining the connections between cases, and can involve the analysis moving to a theoretical level where shared concepts are represented through themes across cases. This can lead to the renaming of themes as the meaning of these ideas begin to reconfigure in light of examining across the data set. The master table of themes developed is outlined in Appendix Z.

Validity of Research

IPA is grounded in philosophical traditions of phenomenology and perceiving knowledge of ourselves and our world to be mediated by the contextual factors we reside in, such as language and culture (Yardley, 2017). This stance conflicts with the more traditional scientific ambition of gaining objective knowledge and poses a dilemma for conducting qualitative research in a manner that ensures validity and reliability (Yardley, 2017). This has become a growing focus in the development of qualitative research methodology (Smith et al., 2009). Yardley (2000) offers a criterion by which qualitative research can be assessed for

quality and validity that is viewed as an appropriate method to assess IPA research (Smith et al., 2009), which comprises four principles: sensitivity to context, commitment and rigour, transparency and coherence, impact and importance.

In the empirical paper, sensitivity to context is demonstrated particularly in relation to the research area of drug use. Smith et al. (2009) highlight a close awareness of the interview process as an important part in promoting sensitivity to context. In this regard, the primary researcher in this empirical study attempted to promote an empathic stance, manage complex power dynamics between researcher and participant, and maintain an appreciation for the interactional aspect of the interview process. Yardley (2000) describes researcher awareness of the existing literature both with regards to the field of research and the research method. As a further demonstration in the empirical paper, the selection of IPA as a method showed sensitivity towards the importance of context in exploring opiate users' lived experience through an idiographic approach.

Commitment by the researcher was demonstrated through the approach to interview in ensuring the participants' comfort and attending closely to the discourse, and also through the care with which the analysis was conducted on each interview transcript. Rigour refers in part to the completeness of the data collection and subsequent analysis (Yardley, 2000). With respect to the current study, the adequacy of the sample in terms of both size and richness of the discourse it provided, along with analysis that attempted to promote prolonged exploration of the data, whilst also considering researcher reflexivity and the hermeneutic process, demonstrate the thoroughness or rigour applied to the study.

With respects to transparency, the researcher made attempts to provide clear explanations and descriptions of the various processes of the study including recruitment, participant selection, interview guide and analysis process. Further examples of research reflexivity including research diaries and analysis have also been provided. In terms of

coherence, this study, in relation to research questions and how it was subsequently conducted, appears to fit well with the IPA methodology and adheres to its underlying theoretical assumptions. Additionally, the findings from this study provide a consistent and coherent narrative, whilst also incorporating and acknowledging inconsistencies between participant accounts.

In considering the impact and importance of this current study, Yardley (2000) describes qualitative methodology as placing emphasis on research in context, which links well to research and practice. This study sheds light on the complex dilemmas that people who use opiates may face in relation to treatment and relationships, providing explanations for people's difficulty in working towards recovery from opiate use, and offering some important considerations for potential solutions for drug and alcohol treatment services in supporting this population.

Chapter 5

Discussion and Critical Evaluation

Word Count: 3,098

Discussion and Critical Evaluation

This chapter considers both the findings of the systematic review and of the empirical paper and how they contribute to the field by understanding the relationships amongst drug-using couples; it also considers the wider research and clinical implications of the project findings. Additionally, strengths and weaknesses of the study are discussed and reflections on the research process are made by the primary researcher.

Systematic Review Critical Review

Consolidation of the qualitative literature on drug-using couples, has, to the best of reviewer's knowledge, not been previously attempted. As discussed in the systematic review paper, in previous research, the focus is typically on the individual rather than on a wider social context or the relationship dyad, which perhaps explains the dearth of synthesised research focussed on drug-using couples. The papers included within the review involve participants from a range of differing nationalities (across high and low income) and cultures, and include qualitative accounts of individuals of opiate-using couples from studies exploring different facets of their lived experience, including homelessness, opiate initiation, opiate treatment and health (i.e. HCV or HIV) treatment. Despite the aforementioned heterogeneity across the studies, some key concepts and themes bridged many of the accounts of individuals in opiate- using relationships.

This review provides some poignant insights into the relationship experiences of drug-using couples, with complexity and duality being key concepts. It offers accounts of relationship experiences that fortify and aspects that destabilise the couple, while also offering insights into the complex gendered relationship dynamics that seem to permeate both drug and non-drug related experiences of relationship activity. The review also highlights how these relationships influence treatment for opiate dependency, in some cases undermining treatment and in others, providing a supportive foundation for change.

Although qualitative research offers a rich and helpful platform for healthcare services to understand people's experiences with health conditions and other relevant phenomena, there has been a concern that qualitative research is often conducted in isolation and does not link systematically with previous research (Zimmer, 2004). Qualitative meta-synthesis has been posited as a method that could overcome these concerns (Zimmer, 2004; Woods, 2005). However, Sandelowski et al. (1997) reflect that the synthesis of qualitative research in some ways violates the underpinning philosophy of qualitative inquiry, questioning how qualitative meta-synthesis resolves issues of differing qualitative methodologies, use of language by authors and descriptions based on differing contexts and environments (Jensen & Allen, 1996). Paterson et al. (2001) offer a perspective on some of these issues, outlining that different studies can be treated as differing perspectives on a particular phenomenon, similar to how individual participant accounts are considered in relation to others within single qualitative studies, but acknowledge that differing accounts of studies must be considered thoroughly when developing higher level themes. Zimmer (2004) also considers these issues and acknowledges the challenges to the validity of qualitative meta-synthesis, particularly in that combining different research analyses poses a specific challenge to this approach. He concludes, however, that qualitative meta-synthesis does have a role in bringing together research to contribute to the field of clinical practice and knowledge. In relation to this systematic review, Noblit and Hare (1988) offer a guide to how to synthesise multiple study perspectives to draw together findings within a meta-ethnographic approach.

The systematic review was conducted using a meta-ethnographic approach of which certain aspects of this approach can be viewed as strengths and others as weaknesses. This method was selected as it has been recommended as suitable in generating higher order theories of experience and the studies that explore particular phenomena lend themselves

well to developing third order themes, due to their rich description of the phenomena (Atkins, 2008). Meta-ethnographical approaches have been used within healthcare research, usually to explore questions of experience in care or of a certain condition (Campbell, 2003; Pound, 2005). It has been argued that this type of meta-synthesis approach has strengths in its ability to maintain the interpretive properties of the original data. However, some questions have been raised about its methodology in synthesising research that utilises differing theoretical perspectives (Atkins, 2008). This is a particular point of interest for the current systematic review, because the studies included used a range of analysis methods, including grounded theory, thematic analysis, content analysis and modified variants of these.

Assessment of quality of studies is another contentious area in meta-ethnographic research (Mays & Pope, 2000). The current review chose to use a quality assessment tool, Critical Analysis Skills Programme (CASP), to assess the components of the studies that seemed important for the review question. The variation in quality of the included studies was commented on in the systematic review chapter. Assessment tools are typically used to aid the researcher in removing studies that are poorly conducted and may introduce bias to the synthesised results. However, the research team took a decision to apply the CASP tool but to include each study in the analysis, regardless of their CASP score. This was to prevent an over rigorous application of the tool criteria that could potentially remove intuitively useful research, with verbatim participant accounts that would contribute significantly to the understanding of relationship and opiate use experience; a similar approach has been used in other meta-ethnographies (Atkins, 2008).

With regards to the data synthesis, both author and participant accounts were incorporated into the generation of themes, in an attempt to not privilege one data source over the other. It appeared that themes generally resonated across studies in terms of author accounts and participant interview excerpts. This is reflected in the results section, where

both author and participant accounts are presented to support the subordinate and higher-level themes.

Empirical Paper Critical Review

The aim of the empirical paper was to explore the experience of treatment whilst in an opiate-using couple where the partner was not engaging in treatment, within a UK context. This was to address a gap in the literature in terms of understanding the lived experience of such people, to understand from a more nuanced perspective how this influenced their treatment goals and perceived recovery. An IPA approach was well placed to achieve the aims of this paper as it is valuable in exploring experiences that can be ambiguous and complex, but also in allowing participants to recount their experience in as full an account as possible (Smith & Osborn, 2015).

One of the main limitations of the study was the difficulty in recruiting sufficient participants for interview. The study had aimed to recruit six to eight participants, in line with Turpin et al. (1997) who suggest that British clinical psychology doctoral programmes recommend six to eight participants as appropriate for an IPA study. This size sample gives an opportunity to examine similarities and differences between individuals. However, as this study was part of a doctoral programme research portfolio, time constraints borne out of wider organisational issues created limitations to some of the research processes. As mentioned in the empirical paper chapter, the project was developed in collaboration with a drug and alcohol treatment service in the East of England, whose lead consultant psychiatrist was involved throughout the project conception and the wider service was involved in consultation and interview topic guide development. This service, however, was re-commissioned to a third sector provider during the final stages of ethical approval. This resulted in delays to participant recruitment as new ethical approval was sought from the UEA Faculty of Research Ethics Committee.

Once all appropriate ethical approval was achieved, the researcher was able to liaise with key workers within the service to develop recruitment links. A further challenge to recruitment was then identified, as key worker caseloads were reconfigured following the change in service provider, meaning that they no longer knew their newly allocated patients well and were unable to ascertain who might be appropriate for inclusion in the study. Five participants were identified within the shortened recruitment phase, which is still noted as an appropriate number of participants for IPA research (Smith, 2004; Smith & Osborn, 2003). Additionally, on reflecting on the interviews conducted in consultation with other members of the research team, the participant's accounts provided rich and in-depth data which seemed to centre on the phenomena that this study set out to focus on. In this respect, the data gathered was deemed adequate to fully answer the research question.

This experience offers a key learning experience for future research, particularly in the drug and alcohol service field and perhaps generally, within healthcare services, in which commissioning frameworks mean that service providers can change. Research teams should ensure contingency plans for recruitment and service engagement, maintaining a reflexive, responsive and flexible approach, given the possibility that gatekeepers could change during the research project.

When considering the perceived small sample size, it must also be recognised that this research was recruiting participants who are deemed 'hard to reach' both clinically and for research purposes (Wiebel, 1990; Griffiths, 1993) and are, as mentioned in the empirical paper chapter, seldom heard. Therefore, the achieved sample size represents a suitable sample size for an IPA study and has been able to illuminate the worldview of a group who are not usually captured in research. Another strength regarding the sample of the study was that participant group characteristics were reflective of the reported statistics of problem opiate users, with Public Health England (2018) stating that 85% of people in opiate treatment were

White British and 90% identifed as heterosexual. All participants interviewed were White British and within heterosexual relationships. Opiate users in treatment have a median age of 40 (Public Health England, 2018), which seemed to be reflected in the study, with participants' age ranging between 39 and 55 years, with a mean of 45 years.

One of the strengths of this study was that the interviewer was a clinical psychologist trainee and had experience of developing alliances and rapport with people who might be hard to engage. This seemed to help promote connections with the participants, allowing them to feel comfortable early within the process and allowing the researcher to use interviewing skills to elicit in-depth responses based on the research aims. A further potential strength of the study was that the primary researcher did not come from a clinical background in drug dependency, having limited personal and professional experience in working with people with drug dependency related problems. This facilitated the researcher to maintain a somewhat open-mind in approaching the data analysis. One of the main components of IPA data analysis is considering how to bracket one's own assumptions or beliefs on the interviewee experience, and although any researcher will bring some level of personal belief to the subject matter, having in-depth personal experience in the research area could in some ways complicate the double hermeneutic process further. The lead researcher held a position as both a trainee clinical psychologist and researcher, and could be viewed to be holding dual perspectives during the interviews and analysis. Further to this, researcher reflexivity was central to the research process, with a diary being kept throughout the process as well as discussions held within research supervision on the open coding and personal reflections, thus helping to minimise any present biases, in line with the IPA approach (Larkin & Thompson, 2012).

All interviews were transcribed by the primary researcher. This facilitated the primary stage of immersing the researcher in the data, recommended as a helpful process in IPA

(Smith et al., 2009). As a relative novice to IPA research, I found this an invaluable step in engaging with the data at a more nuanced and in-depth level, which I believe enhanced the coding development, bringing to the fore the utterances, silences and emphases placed on certain words, as well as capturing times where participants would parody or imitate their partners. This intense immersion also aided my attempts to maintain an awareness of the double hermeneutic and bracketing processes.

Extended Discussion

The United Kingdom's current national policy towards drug treatment emphasises a recovery approach in which treatment focuses on detoxification and moving people toward abstinence (HM Government, 2017), following a move away from the previous policy approach of harm reduction or minimisation. Opiate substitution treatment (OST) has been viewed as effective in the treatment of opiate dependency (Strang et al, 2012) and has shown to support problem opiate users' stability and ability to engage in meaningful commitments in life (Notley, 2013). The findings from this empirical paper support this, with all participants engaging in OST and a majority of participants describing making moves towards vocational work, gaining housing etc. Accounts from the participants provide insight into how they make sense of their recovery in idiosyncratic ways, which highlights the difficulty that services may have in creating and co-ordinating support services. Notley et al. (2015) outline the need for approaches that develop and define idiosyncratic recovery goals for individuals, alongside flexible interventions and timescales for treatment. The empirical paper supports this notion and posits that psychosocial interventions such as Cognitive Behavioural Therapy (CBT) or motivational interviewing could focus on identifying meaningful values and goals of people in treatment and also offer support in developing an identity separate from being an 'addict'.

That considered, the findings from both the systematic review and empirical paper highlight the impact of intimate relationships on treatment engagement and response. The systematic review and empirical paper together were developed to bridge this gap in the literature and offers a first step towards an understanding of the impact of these relationships within a UK context. The findings from the systematic review contribute to the understanding that opiates and substance misuse behaviour form a significant part of the relationship, and in turn, consolidate the relationship over time

Implications for Service Delivery and Clinical Psychology

A highly important finding from the systematic review was the theme of interpersonal abuse and control, particularly from male partners. In relation to the experience of domestic violence, although denying current experience, participants of the empirical paper described past relationships where they experienced violence or other forms of abuse by their partners. The Department of Health (2017) highlights the high prevalence of domestic abuse and intimate partner violence within couples who are dependent on drugs and or alcohol. NICE guidelines (2014) outline the need for multiagency work to identify and support people who are experiencing domestic abuse. NICE (2014) also state that staff within drug services should be aware of protocols for assessing and working with people who both perpetrate and experience domestic violence and abuse. This is recommended in the Department of Health's (2017) guidelines on the clinical management of drug misuse and dependence. Services may benefit from auditing clinical notes or service assessment material to ensure that questions on domestic abuse are routinely asked, and that all staff are trained and aware of domestic abuse and how to work with both victims and perpetrators.

The Department of Health (2017) recommends psychosocial interventions for people in treatment for drug dependency, including motivational interviewing and contingency management, to optimise Opiate Substitution Treatment (OST). Within a phase deemed

'Behavioural Change' of a model of phased interventions, family and social network interventions are recommended, including Social Behaviour Network Therapy (SBNT). This approach attempts to foster a social network conducive to altering drug use and other related behaviour, ideally developing a positive social support network whilst reducing support for continued use. This approach links with the findings from the empirical paper, particularly when considering how to best support someone towards an identity change from holding a fixed self-view of being an 'addict', which seems to be impaired by an unsupportive social environment or lack of non-drug using social contacts (Kearney and O'Sullivan, 2003). Despite the outlined need for social network-based interventions and its demonstrated effectiveness, few drug and alcohol services offer these treatments (Copello & Orford, 2002). This may be due to time or resources constraints of services but also a perceived lack of confidence in delivering these interventions, due to limited training or supervision (Day et al., 2013). Nevertheless, the findings of the systematic review and empirical paper together reassert the need for the consideration and implementation of approaches that encapsulate systemic and social change.

Additionally, highly specialised psychological interventions such as cognitive behavioural approaches, including traditional Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT) and Mindfulness-based relapse prevention, are also specified as some of the main interventions within the Behavioural Change phase by the Department of Health (2017). These interventions should be delivered by appropriately trained clinicians, typically clinical psychologists or other health care professionals supervised by clinical psychologists (BPS, 2012). Additionally, the Department of Health (2017) outline the need to provide trauma-informed care, due to the high level of prevalence of people with trauma histories presenting with drug use problems. This is supported by the findings of both the systematic review and empirical paper, which both highlight the

adversity, psychological and physical harm people who use opiates experience, both within relationships and within other contexts.

The Advisory Council on the Misuse of Drugs (ACMD, 2017) welcomed the HM Government (2017) Drug Strategy; however, the ACMD questioned how the aspirations of the strategy could be implemented, raising issues relevant to clinical psychologists and their role in the changing landscape of drug treatment services in the UK. The British Psychological Society (BPS) (2012) stated that making successful changes to drug and alcohol problems requires changes to behaviour, cognition, circumstances and environment. Clinical Psychologists are uniquely placed among drug and alcohol misuse treatment professionals as having advanced training and expertise to assist and support people to make these changes and in delivering psychological interventions. Since drug and alcohol services were transferred to public health in local authorities, the level of inclusion of clinical psychologists varies considerably between providers (ACMD, 2017), with many treatment services having no Clinical Psychologists at all. The Advisory Council on the Misuse of Drugs Committee (2017) outlined evidence from professional bodies including the BPS and Royal College of Psychiatrists (RCPsych) who highlighted that the persistent re-procurement of services resulted in significant reductions in resources and in a lower quality service per patient. The ACMD (2017) report also draws attention to the shift away from higher cost but highly skilled and trained professionals, including psychiatrists and clinical psychologists, towards more cost-effective clinical assistants and peer mentors. Psychosocial interventions delivered in groups is also recommended by the Department of Health (2017), seen as a way to deliver treatment to a high number of individuals whilst also encouraging mutual support and peer identification. However, group-based interventions are recommended in combination with one-to-one support. This potentially leaves gaps in how high quality and

complex psychological interventions will be delivered to the advantage of the people experiencing drug use problems within drug-using couples.

Additional Methodology and Discussion and Critical Evaluation Reference List

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Appendix A – Author Guidelines for Journal of Drug and Alcohol Dependence

Article structure

Subdivision - numbered sections
Divide your article into clearly defined and numbered sections. Subsections should be numbered 1.1 (then 1.1.1, 1.1.2, ...), 1.2, etc. (the abstract is not included in section numbering). Use this numbering also for internal cross-referencing: do not just refer to 'the text'. Any subsection may be given a brief heading. Each heading should appear on its own separate line.

Introduction
State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods
Provide sufficient details to allow the work to be reproduced by an independent researcher. Methods that are already published should be summarized, and indicated by a reference. If quoting directly from a previously published method, use quotation marks and also cite the source. Any modifications to existing methods should also be described.

Results
Results should be clear and concise.

Discussion
This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.

Conclusions
The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

Essential title page information

• **Title.** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.
• **Author names and affiliations.** Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. You can add your name between parentheses in your own script behind the English transliteration. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.
• **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. This responsibility includes answering any future queries about Methodology and Materials. **Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author.**
• **Present/permanent address.** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be

indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Structured abstract

A structured abstract, by means of appropriate headings, should provide the context or background for the research and should state its purpose, basic procedures (selection of study subjects or laboratory animals, observational and analytical methods), main findings (giving specific effect sizes and their statistical significance, if possible), and principal conclusions. It should emphasize new and important aspects of the study or observations.

Abstracts should be structured with specific sections describing the background, methods, results and conclusions with a maximum of 250 words.

Graphical abstract
Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. You can view Example Graphical Abstracts on our information site.
Authors can make use of Elsevier's Illustration Services to ensure the best presentation of their images and in accordance with all technical requirements.

Highlights
Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). You can view example Highlights on our information site.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations

Define abbreviations that are not standard in this field at their first mention in the text. Ensure consistency of abbreviations throughout the article.

Formatting of funding sources
List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Units

Follow internationally accepted rules and conventions: use the international system of units (SI). If other units are mentioned, please give their equivalent in SI.

Footnotes

Footnotes should be used sparingly. Number them consecutively throughout the article. Many word processors can build footnotes into the text, and this feature may be used. Otherwise, please indicate the position of footnotes in the text and list the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

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• Embed the used fonts if the application provides that option.
• Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Provide captions to illustrations separately.
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A detailed guide on electronic artwork is available.

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If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format.
Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
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TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.
TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of

1000 dpi.
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Please do not:
• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
• Supply files that are too low in resolution;
• Submit graphics that are disproportionately large for the content.

Color artwork
Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. **For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article**. Please indicate your preference for color: in print or online only. Further information on the preparation of electronic artwork.

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Figure captions
Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication

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Reference links
Increased discoverability of research and high quality peer review are ensured by online links to the sources cited. In order to allow us to create links to abstracting and indexing services, such as Scopus, CrossRef and PubMed, please ensure that data provided in the references are correct. Please note that incorrect surnames, journal/book titles, publication year and pagination may prevent link creation. When copying references, please be careful as they may already contain errors. Use of the DOI is highly encouraged.

A DOI is guaranteed never to change, so you can use it as a permanent link to any electronic article. An example of a citation using DOI for an article not yet in an issue is: VanDecar J.C., Russo R.M., James D.E., Ambeh W.B., Franke M. (2003). Aseismic continuation of the Lesser Antilles slab beneath northeastern Venezuela. Journal of Geophysical Research, https://doi.org/10.1029/2001JB000884. Please note the format of such citations should be in the same style as all other references in the paper.

Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references
This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

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1. *Single author:* the author's name (without initials, unless there is ambiguity) and the year of publication;
2. *Two authors:* both authors' names and the year of publication;
3. *Three or more authors:* first author's name followed by 'et al.' and the year of publication.
Citations may be made directly (or parenthetically). Groups of references should be listed first alphabetically, then chronologically.
Examples: 'as demonstrated (Allan, 2000a, 2000b, 1999; Allan and Jones, 1999). Kramer et al. (2010) have recently shown ....'
List: References should be arranged first alphabetically and then further sorted chronologically if necessary. Abbreviated words in journal titles should be followed by a full stop. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.
Examples:
Reference to a journal publication:
Van der Geer, J., Hanraads, J.A.J., Lupton, R.A., 2010. The art of writing a scientific article. J. Sci. Commun. 163, 51–59.
Reference to a book:
Strunk Jr., W., White, E.B., 2000. The Elements of Style, fourth ed. Longman, New York.
Reference to a chapter in an edited book:
Mettam, G.R., Adams, L.B., 2009. How to prepare an electronic version of your article, in: Jones, B.S., Smith , R.Z. (Eds.), Introduction to the Electronic Age. E-Publishing Inc., New York, pp. 281–304.
Reference to a dataset:
Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T., 2015. Mortality data for Japanese oak wilt disease and surrounding forest compositions. Mendeley Data, v1. http://dx.doi.org/10.17632/xwj98nb39r.1.

Journal Abbreviations Source

Abbreviations of journal titles should conform to those used by Index Medicus (http://www.nlm.nih.gov/tsd/serials/lji.html).

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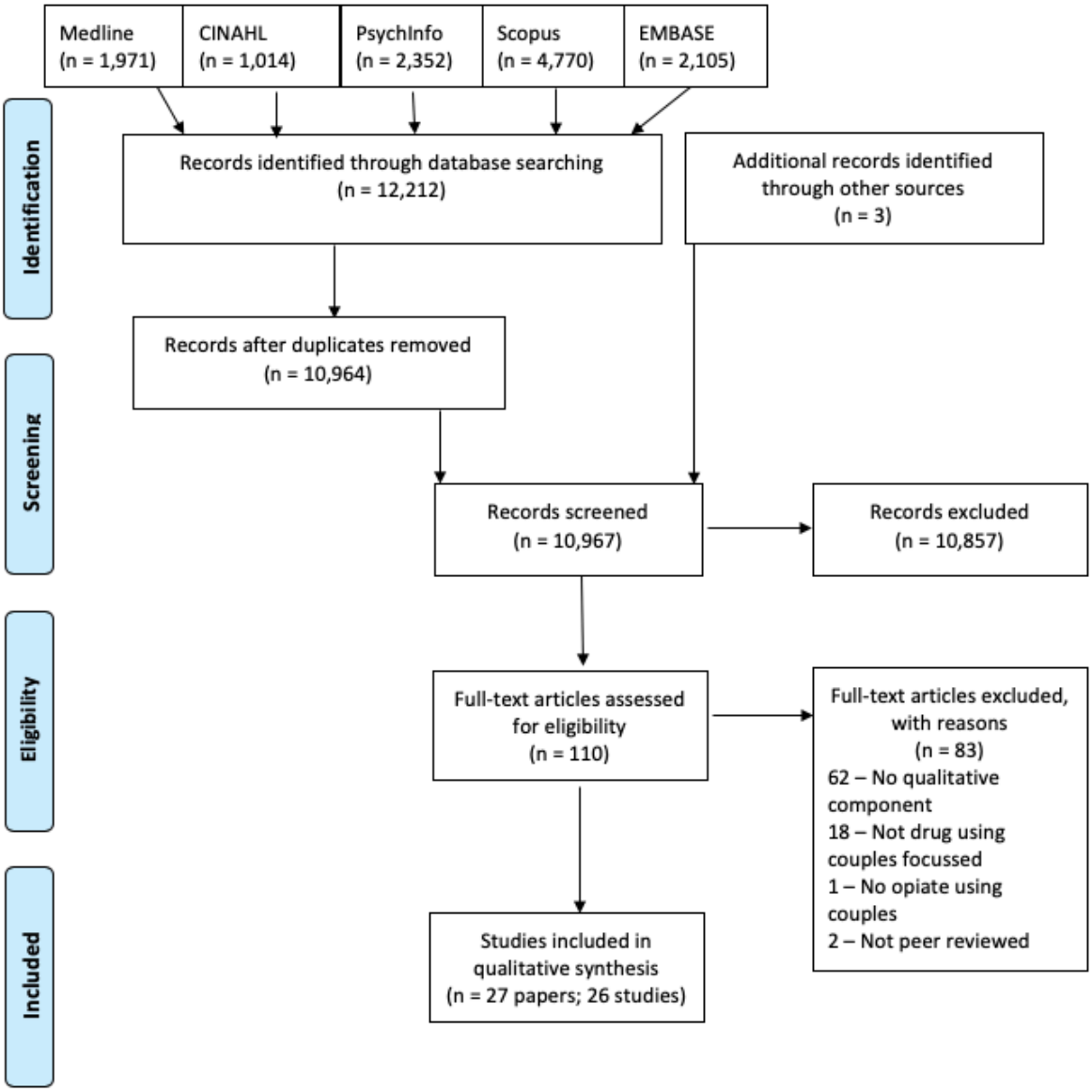
This journal encourages and enables you to share data that supports your research publication where appropriate and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Appendix B - Text Strings used in Database searches

Database	Search String
MEDLINE (EBSCO)	MM "Substance Abuse, Intravenous" OR MM heroin OR MM "substance-related disorders" OR "opioid-related disorders" OR heroin ti,ab OR opioid ti,ab, OR opiate ti,ab AND couples OR marriage OR husband OR wives OR wife OR marit* OR dyad* OR "significant other" OR partner OR cohabitation OR spouse (ti,ab)
PsychInfo (EBSCO)	MM Heroin OR MM Opiates OR MM Drug abuse OR Opioid ti,ab OR heroin ti,ab OR Opiate ti,ab AND MM couples OR couples OR marriage OR husband OR wives OR wife OR marit* OR dyad* OR "significant other" OR partner OR cohabitation OR spouse (ti,ab)
EMBASE (Ovid)	substance abuse OR heroin OR opiate OR opioid (ti,ab) AND couples OR marriage OR husband OR wives OR wife OR marit* OR dyad* OR "significant other OR partner OR cohabitation OR spouse (ti,ab)
CINAHL (EBSCO)	MM substance use disorder OR MM narcotics OR MM heroin OR opiate ti,ab OR opioid ti,ab OR heroin ti,ab AND couples OR marriage OR husband OR wives OR wife OR marit* OR dyad* OR "significant other OR partner OR cohabitation OR spouse (ti,ab)
Scopus	heroin OR opiate OR opioid OR "Opioid-Related Disorders" OR "Substance-Related Disorders" - All title, abstract, keyword AND ("significant other") OR spouse OR marriage OR marit* OR couples OR husband OR wife OR wives OR partner OR cohabitation OR dyad* - All Title, abstract, keyword AND (LIMIT-TO (LANGUAGE,"English ")) AND (LIMIT-TO (EXACTKEYWORD, "Human"))

Appendix C – PRISMA flow diagram of the study selection process



Appendix D – Characteristics of Synthesised Studies

Study Title	First Author, Date and Country	Sampling Technique	Number of total Participants	Method	Qualitative Analysis	CASP Rating
'We did more rough sleeping just to be together' – Homeless drug users' romantic relationships in hostel accommodation	Stevenson et al., (2012) UK	Purposive and snowballing sampling.	40 individuals who were classified as homeless drug users.	Completed semi-structured interviews with individuals.	Framework analysis	7.5
"Don't think I'm going to leave you over it": Accounts of changing hepatitis C status among couples who inject drugs	Rance et al., (2017) Australia	Purposive sampling	80 individuals from heterosexual couples in where both members of the relationship identified as people who inject drugs (PWID).	Completed in-depth semi-structured interviews lasting 30-60 minutes.	Mix of inductive (data-driven) and deductive (analyst-driven) approaches	7.5
Gender Relations in Addiction and Recovery	Amaro et al., (1995) USA	Randomly selected from larger sample of 546 women, who were participating in a community-based HIV prevention programme.	35 pregnant drug-using female	In-depth interviews centred on life history approach	Computer software "The Ethnograph" used for text-based analysis	5.5
Barriers to Drug Treatment for IDU Couples: The Need for Couple-Based Approaches	Simmons et al., (2012) USA	Purposive sampling	25 drug using couples and 19 treatment providers were interviewed.	Individual ethnographic interviews lasting between 45 – 90mins.	Modified Grounded Theory	5.5

Boyfriends and injecting: the role of intimate male partners in the life of women who inject drugs in Central Java	Lazuardi et al., (2012) Indonesia	Purposive sampling	19 females from Central Java.	Quantitative survey data. Qualitative interviews, semi-structured.	Grounded theory	5.5
Drug Use and Sexual Behavior: The Multiple HIV Vulnerabilities of Men and Women Who Inject Drugs in Kumasi, Ghana	Messersmith et al., (2015) Ghana	Purposive and snowball sampling	30 individuals classed as people who inject drugs (PWID) and 6 HIV program managers and health service providers.	Qualitative, in-depth interviews.	Thematic analysis	8.5
Surviving in two worlds: Social and structural violence of Thai female injecting drug users	Haritavorn (2014) Thailand	Snowball technique	35 female drug users participated in total. Additionally, five participants were involved in focus groups	Qualitative, two focus groups with five key informants, and individual in-depth interviews.	Thematic Analysis	7
I love you ... and heroin: care and collusion among drug-using couples	Simmons et al., (2006) USA	Purposive sampling	Ten drug using couples	Qualitative individual semi-structured interviews with each member of a drug using couple	Grounded theory	6.5
Is peer injecting a form of intimate partner abuse? A qualitative study of the experiences of women drug users	Wright et al., (2007) UK	Purposive sampling	45 female participants	Qualitative interviews lasting up to 90 minutes.	Grounded theory	7
Relational Pathways to Substance Misuse and Drug-Related Offending in Women: The Role of Trauma, Insecure Attachment, and Shame	Kreis et al., (2016) UK	Purposive sampling	Seven female participants. All offenders in community treatment for heroin use.	Qualitative, semi-structured interviews.	Ground theory	9

Gendered power dynamics and HIV risk in drug-using sexual relationships	MacRae et al., (2000) UK	Purposive sampling	90 participants; 63 female, 27 males.	Qualitative, semi-structured interviews. Supplemented by observation of participants in various settings.	Deviant case analysis	6.5
Male Heroin Addicts and Their Female Mates: Impact on Disorder and Recovery	Lex, B. (1990) USA	Couples selected through 'representative case method'.	Six couples; three where male partner was using heroin, two couples where the male was abstinent from heroin, and one couple where the male was in treatment for heroin use.	Qualitative interview exploring life history reports and ethnographic observations were also obtained.	Qualitative analysis unspecified.	3.5
The Risk Environment of Heroin Use Initiation: Young Women, Intimate Partners, and "Drug Relationships"	Mayock et al., (2015) Republic of Ireland	Purposive sampling	40 participants; 23 male, 17 females, lifetime users of heroin.	Mixed methods: Quantitative survey examining epidemiological description of heroin using participants. Qualitative interview; life history interviewing.	Grounded theory analysis	8
More than just someone to inject drugs with: Injecting within primary injection partnerships	Morris et al., (2015) Australia	Purposive sampling	Nine couples were interviewed. Four were male-female partnerships, one was a male-male partnership, three were family member relationships.	Qualitative semi-structured interviews, lasting between 45-80 minutes.	Content analysis	8
Practices of partnership: Negotiated safety among couples who inject drugs	Rance et al., (2018) Australia	Purposive sampling	34 couples and 12 individual participants.	Qualitative semi-structured interviews, lasting between 30-60mintues. Participants were interviewed separately.	'Interactive model' analysis guided by a previous partnership study.	8

Rethinking safety and fidelity: The role of love and intimacy in hepatitis C transmission and prevention	Seear et al., (2012) Australia	Purposive sampling	15 participants interviewed, 9 male and 6 females.	Qualitative, semi-structured interviews.	'Interactive model' analysis	7.5
Retrospective accounts of injection initiation in intimate partnerships	Simmons et al., (2012) USA	Purposive sampling	45 participants; 14 initiated to intravenous drugs by peers, 12 by family members, nine by an adult and ten within intimate relationships.	Qualitative, semi-structured interviews, lasting 90-105 minutes.	Prioritisation of narrative presentation over thematic	7.5
Drug Users' Sexual Relationships and the Social Organisation of Risk: The Sexual Relationship as a Site of Risk Management	Rhodes et al., (1998) UK	Purposive and snowballing sampling	72 participants; 46 male and 26 females	Qualitative, semi-structured interviews. Lasting between 60-90 minutes.	Inductive analysis	5.5
Risky injecting practices associated with snowballing: A qualitative study	Wilkins et al., (2010) UK	Purposive sampling	18 people that snowball; 13 male, five females	Qualitative, semi-structured interviews, lasting 30-45 minutes.	Qualitative analysis outlined by King (2004)	8
Safer and Unsafe Injection Drug Use and Sex Practices Among Injection Drug Users in Halifax, Nova Scotia	Jackson et al., (2002) Canada	Purposive sampling	60 individual interviews with people who inject drugs; 37 males, 23 females	Qualitative, individual semi-structured interviews. Two focus groups were also used to review feedback on findings.	Qualitative analysis outlined by Strauss (1993)	7

Social and Structural Challenges to Drug Cessation Among Couples in Northern Mexico: Implications for Drug Treatment in Underserved Communities	Bazzi et al., (2017) Mexico	Purposive sampling	214 couples were recruitment for the study. 41 couples were purposively sampled for the qualitative interviews.	Mixed methods; Quantitative survey. Qualitative interviews exploring relationship dynamics and contexts of participants.	Thematic analysis	6.5
Social influences on the transition to injection drug use among young heroin sniffers: a qualitative analysis	Sherman et al., (2002) USA	Convenience sampling	19 participants, from a larger study of intravenous drug users	Qualitative study, semi-structured interviews.	Thematic analysis	7
Rethinking Risk; Gender and injection drug-related HIV risk among female sex workers and their non-commercial partners along the Mexico-US border	Syvertsen et al., (2014) Mexico	Purposive sampling	Subsample of 41 from 214 couples of integrated longitudinal study of HIV/STI risk.	Mixed methods; quantitative surveys and qualitative semi-structured interviews. Combination of individual and couples' interviews. Ethnographic fieldwork also conducted	Thematic analysis	7.5
The interplay between interpersonal dynamics, treatment barriers, and larger social forces: an exploratory study of drug-using couples in Hartford, CT	Simmons et al., (2006) USA	Purposive sampling	Ten drug-using couples were interviewed. At least one member had to be an injection drug user, and both had to use heroin, cocaine or both on a daily basis.	Qualitative, semi-structured interviews with drug using couples.	Grounded theory	7.5
The intimate relationship as a site of social protection: Partnerships between people who inject drugs	Rhodes et al., (2017) Australia	Purposive sampling	34 couples, each interviewed separately, and 12 additional individual interviews.	Qualitative, semi-structured interviews, both couple and individual interviews.	Thematic analysis	7.5

The power of relationships: Implications for safer and unsafe practices among injection drug users	Jackson et al., (2010) Canada	Purposive sampling	38 participants were interviewed; 23 male, 15 females	Qualitative, semi-structured interviews, with participants who reported injecting the previous year.	Grounded Theory analysis	8
Understanding decisions made about hepatitis C treatment by couples who inject drugs	Treloar et al., (2016) Australia	Purposive sampling	34 couples and 12 individual participants.	Qualitative semi-structured interviews. Members of couples were interviewed individually.	Dyadic interview analysis	7.5
When Drugs Come into the Picture, Love Flies out the Window: Women Addicts' Love Relationships	Rosenbaum (2009) USA	Purposive and snowballing	100 female heroin users were interviewed.	Qualitative semi-structured interviews.	Unspecified analysis	3.5

Appendix E – Example of Development of Conflict Subordinate Theme into Superordinate Theme

Original Study	Account	Code	Subordinate Theme	Superordinate Theme
Haritavron (2014)	"My boyfriend hits me badly. He kicks me and slaps my face whenever I get a little bit of heroin. If I got more, he would suspect that I slept with a drug dealer".	Physical Violence	Conflict	Heroin influenced destabilisers
Simmons et al., (2012)	"That's crazy. I've said some cruel things because of the drugs."	Arguments triggered by opiate use	Conflict	Heroin influenced destabilisers
MacRae et al., (2000)	"we found that much of the conflict between the couples appeared to be about the division of drugs and money rather than about injecting outside of the relationship or needle sharing."	Conflict caused by opiate division	Conflict	Heroin influenced destabilisers
Stevenson et al., (2012)	"They're using [drugs] behind each other's backs, arguing ... I've seen lot of breakups in relationships because of them separating people."	Relationship instability caused by opiate use outside of relationship	Conflict	Heroin influenced destabilisers
Wright et al., (2007)	"Generic' emotional and physical abuse in the relationship tended to extend into the injecting situation"	Emotional/physical abuse through injection practice	Conflict	Heroin influenced destabilisers

Appendix F - Superordinate and Subordinate Themes from Meta-Synthesis

Superordinate theme	**Subordinate theme**
Centrality of Heroin	Sharing Needles and Drugs Heroin Bonding Initiating heroin within relationship Heroin is given priority Joint Heroin-related activities
Relationship Constructors	Unique relationship Safety Reciprocal Care Love & Intimacy
Heroin Influenced Destabilisers	Conflict Heroin use undermines the relationship Impairment of sexual intimacy Jealousy & Mistrust
Relationship-Addiction Reinforcers	Intimacy in Drug Practices Care & Collusion Enmeshed Relationship Social Network Alienation
Negotiating Recovery	Partner influenced Relapse Aspirations for the Relationship to be Abstinent Relationship influencing Recovery
Gendered Power Dynamics	Male Provider Male Exerting Control Power conflict

Appendix G - Participant Accounts and Author Interpretations

Superordinate Theme	Subordinate Theme	Quotation from participant	Interpretation by authors
Centrality of Heroin			
	Sharing Needles and Drugs	"as time wore on and we sort of realised that we were going to be spending quite a lengthy period of time together, not just a fling kind of thing, it'd develop more into something like 'ours'." Rance et al., (2018)	"Sharing drugs was a cornerstone in these relationships and most couples shared drugs only with each other." Simmons & Singer (2006)
	Heroin Bonding	"It bonds you even closer" Rhodes & Quirk (1998) "Just as heroin often masks physiological disease	"Such relationships were said to give "more of an affinity towards each other because (you're) both doing the same thing"."

		symptoms, it can cover up those aspects of a love relationship that would be intolerable without heroin." Rosenbaum (2009)	Rhodes & Quirk (1998)
	Initiating heroin use within relationship	"I met [ex-husband] and he was into his heroin but I wasn't at the time. Interviewer: Was that, did you get into it through him then? No not through him, I'd touched, I'd touched it before but, I just, I wasn't even thinking about it, and then he came along	

		and it's like 'have you tried heroin?' I says 'I've tried it', he says 'do you fancy getting a bit?' and I was like, when I meet somebody I get all nervous so, like, I says 'aye', my stupid self, and he was actually feeding my habit." Kreis et al., (2016)	
	Heroin is given priority	"Fran explains that in her partnership with Fred drug use "takes over everything else" and is "just a constant"." Rhodes et al., (2017)	"Drugs gradually come to replace all other aspects of the couple's relationship" Rosenbaum (2009)

	Joint Heroin-related activities	"We both [contribute money]. Sometimes he does, sometimes I do, sometimes we share the expense, I pitch in with half and he does the same. . . We both help each other." Syvertsen et al., (2014)	"Strategies to affect this purpose ran the gamut from legal hustles to illegal ones. Julio and Sandra, for instance, spent all of their time collecting recyclable cans to manage their addictions." Simmons & Singer (2006)
Relationship Constructors			
	Unique Relationship	"She's my best friend, she's my lover, she's my partner and my companion" Rhodes et al., (2017)	"Gemma, for example, met her partner outside of her sex work, and together established a connection she had not experienced with other men" Seear et al., (2012)

			"Participants recognized the close familiarity unique to these partnerships" Morris et al., (2015)
	Safety	"Q: Do you feel safe? R:.Yeah, I've had my partner ain't I? If I didn't have my partner I most probably wouldn't have." Stevenson & Neale (2012)	"Both the domestic setting and the intimate relationship were frequently conceptualized and co-produced as (relatively) safe spaces." Seear et al., (2012)
	Reciprocal Care	"We [are] each other's backbone." Simmons & McMahon (2012)	"Glenn and Diana, one of the seven couples who rode a roller coaster of moderate to high drug use, also valued and demonstrated care in their relationships."

			Simmons & Singer (2006)
	Love and Intimacy	"I love him. […] He's just the most beautiful person I've ever met in my life" Rhodes et al., (2017) "the one thing I understand is that we both have the same problem: if we shared strains, then we've both got the same shared strain. It's unfortunate we got to that point, but as long as no one else comes into the mix I feel safe." Rance et al., (2018)	"Many other participants described their partners in similar ways. Some spoke about the sense they had of being loved by their partners unconditionally" Seear et al., (2012) "In some instances, attaining access to such knowledge appeared to act as a catalyst for the establishment of intimacy and trust." Rance et al., (2018)

Heroin Influenced Destabilisers			
	Conflict	"He [ex-boyfriend] used to say to me, 'oh you're not a woman you, you're a thing, if me and you split up, nobody else would go out with you, you'll not get another man because they'll not know whether they are going out with a man or a woman or what they are going out with', he used to call me all sorts." Wright et al., (2007) "Like we have only a little bit of heroin, [and he] goes "'No,	

		you had more than me", and the trouble starts because of things like that." Rhodes & Quirk (1998)	
	Heroin use undermining effect on the relationship	"At first it was love and lust and whatever you want to call it. Then it ended up, I got strung out, and it was like thousands of Euro spent on gear. And we didn't even hug ... We weren't living normal like, we were living the life of a junkie. It was the proper lifestyle of the junkie." Mayock et al., (2015)	"Regular use of the drug generally followed quite quickly and, within a relatively short time, drug acquisition and use became the primary preoccupation of daily life. Some depicted this development as bringing pressure and chaos to their lives as well as undermining other important aspects of the relationship"

			Mayock et al., (2015)
	Impairment of sexual intimacy	“When I was using heroin, I found that I had very little interest in sex. I mean, sex was something I did for money. Sex was something I had very low interest in. Unless I had a strong interest in some other person, well, even then sex was secondary. Drugs took precedence over anything else.. . . sex wasn’t important to my old men either. I’ve discovered this is true of most addicts. Sex was kind of a secondary thing.”	“There was a general consensus that the regular use of heroin, as well as other opioids, was the "kiss of death to anyone's sex life" which "kills the sex drive" and "kills relationships" Rhodes & Quirk (1998)

		Rosenbaum (2009)	
	Jealousy and Mistrust	"Now, I am also not allowed to hang out with them [my friends] anymore .. . I don't know, perhaps he [boyfriend] feels jealous. Hahaha, because most of them are males." Lazuardi et al., (2012)	"mixed sex hostels usually had a large gender imbalance with men outnumbering women by as much as 10–1. This could result in many men pursuing a small number of vulnerable women alongside jealousy and insecurities after relationships were formed" Stevenson & Neale (2012)
Relationship-Addiction Reinforcers			
	Intimacy in Drug Practices	"[Boyfriend] will always make sure that's there's street [antiseptic wipe] there, and he'll like wipe me with it first and like,	"The process of being injected by a male sexual partner appears very much connected to the nature of the relationship and

		he'll take the tourney off for me, and like he'll blow on it as he's pushing it in, and like he'll like do it gently 'cos like some people like they just push it in dead hard and it fucking hurts, but [boyfriend] makes sure he don't, he'll like do it softly 'cos like he, he cares whether he hurts me." Wright et al., (2007) "I usually let her [inject] first, even though she's the one who's got hep C . . . To me she's still my lady and she goes first no matter what"	the emotional investment placed in such. In contrast to the men, many of the women described their injecting behaviour in sentimental terms that expressed notions of togetherness and intimacy" Amaro & Hardy-Fanta (1995)

		Rance et al., (2017)	
	Care and Collusion	"When I was craving for heroin, he knew how to help me. He went out looking for drugs." Haritavorn (2014)	"Care and collusion are part of a dynamic which bonds drug-using couples together in what is often a mutually reinforcing cycle of addiction" Simmons & Singer (2006) "Couples care for each other by helping each other avoid the symptoms of withdrawal. A loved one is "sick," the partner provides the "cure." Simmons & Singer (2006)

	Enmeshed Relationship	“It's kind of become because of the drug use. It's become bad in a way, because it's kind of become, we've become co-dependent on each other, and kind of we use together so it's kind of at least, if something happens you know, it's kind of a bit unhealthy in that way, because we depend so much on each other. It's the using [that] plays a big part of it.” Rhodes et al., (2017)	“For Jim, this “everything together” dynamic de-emphasises individuality in favour of shared experience” Rhodes et al., (2017)

	Social network Alienation	“I became distant from my hangout friends. Because, I no longer hang out with them, until now, and so automatically I became distant from them” Lazuardi et al., (2012)	“Jim, Jenn's partner, similarly envisages their partnership as a “break up from the pack”. Borne out of their social relations of difference, these partnerships may have weaker economic and material ties to the outside” Rhodes et al., (2017)
Negotiating Recovery			
	Partner Influenced Relapse	“It's one of the situations where you, two of you sit there and one person says, "I'm bored, lets get some drugs" and the other says "No we said we weren't gonna do it". The other will go	“Even when both partners are willing to enter treatment and concurrently stop using, if one relapses, the other is almost always sure to follow.”

		"OK, you're right, lets not get it" and then ten minutes later "Alright let's get some"" Rhodes & Quirk (1998) "When asked why she kept doing drugs while knowing she wanted to stop, Arlene replied, simply: "Because he was doing it "" Amaro & Hardy-Fanta (1995)	Simmons & McMahon (2012) "Guilt, or fear of losing the relationship often made it difficult to seriously consider treatment options." Simmons & McMahon (2012)
	Aspirations for the Relationship to be abstinent	"Jacinto relates his confidence that he can convince	

		his partner to enter treatment with him: We just talk about it. If I feel strongly about it, I can talk her into it 'cause I'm tired of this shit. We could do better" Simmons & McMahon (2012)	
	Relationship Influencing Recovery	"We love each other, so we're going to do this together." Simmons & McMahon (2012)	"On the one hand, a shared commitment between partners to reduce or stop drug use was viewed as the most effective way of tackling drug problems whilst protecting the relationship" Rhodes & Quirk (1998)

Gendered Power Dynamics			
	Male Provider	"R: I am the one who always buys the drugs I: Why doesn't the lady also buy some of the drugs? R: It was my duty to provide the drugs as the man" Messersmith et al., (2015)	"The "burden of care" experienced by men who are attempting to fulfil their social role as providers by obtaining and supplying illicit drugs in a normative gendered division of labour is common" Simmons & McMahon (2012) "In the end, she proved to be the better provider because of her greater skill at selling drugs. The dramatic role reversal described above was made all the

			more poignant when Patricia also began to supply Andrés with drugs and half of her clinic-supplied methadone, something he had done for her in the past." Simmons & Singer (2006)
	Male exerting Control	"He was always in control of the drugs, like. He'd get the drugs and he put it on the spoon, he'd cook it up, he'd draw the drugs up into the pin and that and like he wanted to be controlling me, always had to inject me." Wright et al., (2007)	"In the majority (13 out of 16) of drug-using/injecting relationships it was the male partner who had overall control of the money and drugs" MacRae & Aalto (2000)

	Power Conflict	"I was always holding the strings in the relationship and I was real young but I always clicked my fingers and got what I wanted ... Me and (partner) broke up. I'd kind of get back with him but I wouldn't officially and he'd go and buy me gold and hand me hundreds of Euro ... and then I'd get back with him (officially) and the presents would keep rolling and I was loving it" Mayock et al., (2015)	

Appendix H – Author Guidelines for Drugs: Education, Prevention and Policy

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

A typical paper for this journal should be no more than 5000 words inclusive of tables, figure captions, footnotes, endnotes. Editorials are typically between 1-2000 words, and Short reports 2-3000. However, qualitative studies can be up to 8000 words.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word or LaTeX formats. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

A LaTeX template is available for this journal. Please save the LaTeX template to your hard drive and open it, ready for use, by clicking on the icon in Windows Explorer.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

References

Please use this reference guide when preparing your paper.

An EndNote output style is also available to assist you.

Article layout guide

Font: Times New Roman, 12-point, double-line spaced. Use margins of at least 2.5 cm (or 1 inch). Guidance on how to insert special characters, accents and diacritics is available here.

Title: Use bold for your article title, with an initial capital letter for any proper nouns.

Abstract: Indicate the abstract paragraph with a heading or by reducing the font size. Check whether the journal requires a structured abstract or graphical abstract by reading the Instructions for Authors. The Instructions for Authors may also give word limits for your abstract. Advice on writing abstracts is available here.

Keywords: Please provide keywords to help readers find your article. If the Instructions for Authors do not give a number of keywords to provide, please give five or six. Advice on selecting suitable keywords is available here.

Headings: Please indicate the level of the section headings in your article:

1. First-level headings (e.g. Introduction, Conclusion) should be in bold, with an initial capital letter for any proper nouns.
2. Second-level headings should be in bold italics, with an initial capital letter for any proper nouns.
3. Third-level headings should be in italics, with an initial capital letter for any proper nouns.
4. Fourth-level headings should be in bold italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.
5. Fifth-level headings should be in italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.

Tables and figures: Indicate in the text where the tables and figures should appear, for example by inserting [Table 1 near here]. You should supply the actual tables either at the end of the text or in a separate file and the actual figures as separate files. You can find details of the journal Editor's preference in the Instructions for Authors or in the guidance on the submission system. Ensure you have permission to use any tables or figures you are reproducing from another source.

Please take notice of the advice on this site about obtaining permission for third party material, preparation of artwork, and tables.

Running heads and **received dates** are not required when submitting a manuscript for review; they will be added during the production process.

Spelling and punctuation: Each journal will have a preference for spelling and punctuation, which is detailed in the Instructions for Authors. Please ensure whichever spelling and punctuation style you use, you apply consistently.

Format-free submission

An increasing number of Taylor & Francis journals allow format-free submission, which means that, as long as your article is consistent and includes everything necessary for review, you can submit work without needing to worry about formatting your manuscript to meet that journal's requirements. The 'Instructions for authors' for your chosen journal will tell you whether it operates format-free submission.

APA (American Psychological Association) references are widely used in the social sciences, education, engineering and business. For detailed information, please see the Publication Manual of the American Psychological Association, Sixth Edition (2010); http://www.apastyle.org/ and http://blog.apastyle.org/

Appendix I – Research Ethics Committee Favourable Opinion

NHS
Health Research Authority

East of England - Cambridge Central Research Ethics Committee
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0207 1048098

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

20 March 2018

Mr Paul Workman
Trainee Clinical Psychologist
University of East Anglia
Norwich Medical School
University of East Anglia
NR4 7TJ

Dear Mr Workman

Study title:	**The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser**
REC reference:	**18/EE/0037**
IRAS project ID:	**229985**

Thank you for your letter dated 27th February 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

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

1. The following paragraph in the Participant Information Sheet is quite technical and does not add substantial benefit to the participant's understanding of the study, please remove it:

   What's involved?

   The impact of couple relationships in opiate drug treatment appears to be an important issue in treatment maintenance and recovery, yet there is limited qualitative research, in a UK context, exploring the experience of substance misusers engaging with treatment services whilst within a drug using relationship. In depth interview-based research within this population will importantly help understanding of the issues within problem drug using relationships and could possibly shed light on influence of such relationships on treatment and recovery. The study aims to recruit 6-8 participants.

2. Please add this information to the Participant Information Sheet and complete this sentence with the duration of time that you plan to keep the audio recording after details of uploading and transcription. "All audio recordings will be destroyed within [TIME PERIOD] of the end of the study. Transcripts will be kept for [TIME PERIOD] following the end of the study."

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

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

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Recruitment Poster]	1	14 December 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UEA Sponsor Letter including Indemnity Evidence]	1	14 December 2017

GP/consultant information sheets or letters [Key Worker Pro Forma]	1	22 November 2017
Interview schedules or topic guides for participants [Interview Questions]	1	14 December 2017
IRAS Application Form [IRAS_Form_18122017]		18 December 2017
Letter from sponsor [Sponsor Letter]	1	14 December 2017
Other [Consent to Contact]	1	22 November 2017
Other [TV Poster]	1	22 November 2017
Other [Demographic Questions]	1	22 November 2017
Other [Debriefing Sheet]	1	22 November 2017
Other [SCoker CV]	1	08 January 2017
Other [Distress Protocol]	2	27 February 2018
Other [REC Response Letter]	1	27 February 2018
Participant consent form [Consent Form]	2	27 February 2018
Participant information sheet (PIS) [Participant Information Sheet]	2	27 February 2018
Research protocol or project proposal [Thesis Proposal Revised]	1	22 November 2017
Summary CV for Chief Investigator (CI) [CI CV]	1	22 November 2017
Summary CV for supervisor (student research) [Supervisor CV]	1	28 November 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study Flowchart]	1	22 November 2017

Statement of compliance

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

After ethical review

Reporting requirements

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

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and

the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

18/EE/0037	**Please quote this number on all correspondence**

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

Yours sincerely

pp C Hollowell

Dr Lydia Drumright
Chair

Email:NRESCommittee.EastofEngland-CambridgeCentral@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Mr Graham Horne*
Dr Bonnie Teague, NHS

Appendix J – HRA Approval Letter

NHS
Health Research Authority

Mr Paul Workman
Trainee Clinical Psychologist
University of East Anglia
Norwich Medical School
University of East Anglia
NR4 7TJ

Email: hra.approval@nhs.net

03 April 2018

Dear Mr Workman

Letter of HRA Approval

Study title:	**The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser**
IRAS project ID:	**229985**
REC reference:	**18/EE/0037**
Sponsor	**University of East Anglia**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further from the HRA.

How should I continue to work with participating NHS organisations in England?
You should now provide a copy of this letter to all participating NHS organisations in England, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of HRA assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland, Scotland and Wales?
HRA Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland, Scotland and Wales.

If you indicated in your IRAS form that you do have participating organisations in one or more devolved administration, the HRA has sent the final document set and the study wide governance report (including this letter) to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with Northern Ireland, Scotland and Wales.

How should I work with participating non-NHS organisations?
HRA Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Mr Graham Horne
Email: g.horne@uea.ac.uk

IRAS project ID	229985

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **229985**. Please quote this on all correspondence.

Yours sincerely

Kevin Ahmed
Assessor

Telephone: 0207 104 8171
Email: hra.approval@nhs.net

Copy to: *Mr Graham Horne, Sponsor Contact, University of East Anglia*
Dr Bonnie Teague, R&D Contact

IRAS project ID	229985

List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Recruitment Poster]	1	14 December 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UEA Sponsor Letter including Indemnity Evidence]	1	14 December 2017
GP/consultant information sheets or letters [Key Worker Pro Forma]	1	22 November 2017
HRA Schedule of Events	1.0	03 April 2018
HRA Statement of Activities	1.0	03 April 2018
Interview schedules or topic guides for participants [Interview Questions]	1	14 December 2017
IRAS Application Form [IRAS_Form_18122017]		18 December 2017
Letter from sponsor [Sponsor Letter]	1	14 December 2017
Other [SCoker CV]	1	08 January 2017
Other [Distress Protocol]	2	27 February 2018
Other [REC Response Letter]	1	27 February 2018
Other [REC Review Response letter 26-3-18]	1	26 March 2018
Other [Consent to Contact]	1	22 November 2017
Other [TV Poster]	1	22 November 2017
Other [Demographic Questions]	1	22 November 2017
Other [Debriefing Sheet]	1	22 November 2017
Participant consent form [Consent Form]	2	27 February 2018
Participant information sheet (PIS) [Participant Information Sheet]	3	26 March 2018
Research protocol or project proposal [Thesis Proposal Revised]	1	22 November 2017
Summary CV for Chief Investigator (CI) [CI CV]	1	22 November 2017
Summary CV for supervisor (student research) [Supervisor CV]	1	28 November 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study Flowchart]	1	22 November 2017
2018.04.03 REC Ref 18-0037 IRAS ID 229985 FO conditions met		03 April 2018

IRAS project ID	229985

Summary of HRA assessment

The following information provides assurance to you, the sponsor and the NHS in England that the study, as assessed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing, arranging and confirming capacity and capability.

If DA led study, complete HRA assessment criteria as instructed, and complete other sections as normal.

Overwrite "No Comments" when it is appropriate to add comments

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The sponsor has submitted the HRA Statement of Activities and intends for this to form the agreement between the sponsor and study sites. The sponsor is not requesting, and does not require any additional contracts with study sites.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No application for external funding has been made. No study funding will be provided to sites, as detailed at Schedule 1 of the Statement of Activities.

Section	HRA Assessment Criteria	Compliant with Standards	Comments
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For further guidance on working with participating NHS organisations please see the HRA website. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).
A Principal Investigator should be appointed at study sites. GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
Where arrangements are not already in place, network staff (or similar) undertaking any of the research activities listed in A18 of the IRAS form would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix K – UEA FMH Chairs Action Approval Letter

Faculty of Medicine and Health Sciences Research Ethics Committee

Research & Innovation Services
Floor 1, The Registry
University of East Anglia
Norwich Research Park
Norwich, NR4 7TJ

Email: fmh.ethics@uea.ac.uk

Web: www.uea.ac.uk/researchandenterprise

Paul Workman
(MED)

08.05.18

Dear Paul,

Project title: The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser
Reference: 2017/18 - 121

The submission of your above proposal has been considered by the Faculty Research Ethics Committee and I can confirm that your and I/we can confirm that your proposal has been approved by chairs action.

Please could you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Committee. Please could you also arrange to send us a report once your project is completed.

Yours sincerely,

Professor M J Wilkinson
Chair
FMH Research Ethics Committee

Appendix L - REC Amendment Approval

Health Research Authority

East of England - Cambridge Central Research Ethics Committee
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

15 August 2018

Mr Paul Workman
Norwich Medical School
Department of Clinical Psychology
University of East Anglia, Norwich
NR4 7TJ

Dear Mr Workman

Study title:	**The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser**
REC reference:	**18/EE/0037**
Amendment number:	**1**
Amendment date:	**03 August 2018**
IRAS project ID:	**229985**

The above amendment was reviewed on 09 August 2018 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Discussion: There were no ethical concerns raised.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*

NHS
Health Research Authority

Notice of Substantial Amendment (non-CTIMP) [IRAS AmendmentForm_ReadyForSubmission.pdf]	1	03 August 2018
Research protocol or project proposal [Amendment Application - Adding home visits.docx]	2	26 July 2018

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

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

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

18/EE/0037:	**Please quote this number on all correspondence**

Yours sincerely

PP David Parr

Revd Dr Derek Fraser
Chair

E-mail: NRESCommittee.EastofEngland-CambridgeCentral@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Dr Bonnie Teague, NHS*
Mr Paul Workman

Appendix M – Health Research Authority Amendment Approval

Dear Mr Workman,

IRAS Project ID:	229985
Short Study Title:	Couple Relationships in Substance Misuse Populations
Amendment No./Sponsor Ref:	1
Amendment Date:	03 August 2018
Amendment Type:	Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the conditio outlined in your categorisation email.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. I wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact hra.amendments@nhs.net for any queries relating to the assessment of this amendment.

Kind regards

Hayley Kevill
Health Research Authority
Ground Floor | Skipton House | 80 London Road | London | SE1 6LH
E.hra.amendments@nhs.net
W. www.hra.nhs.uk

Appendix N – University of East Anglia Faculty of Medicine and Health Sciences Research Ethics Committee Document Amendment Approval

Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

Research & Innovation Services
Floor 1, The Registry
University of East Anglia
Norwich Research Park
Norwich, NR4 7TJ

Email: fmh.ethics@uea.ac.uk

Web: www.uea.ac.uk/researchandenterprise

Paul Workman
(MED)

23.05.18

Dear Paul,

Project title: The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser
Reference: 2017/18 – 121

Thank you for your letter notifying us of the amendments you would like to make to your above proposal to change the name of the study service from [redacted] hese have been considered and we can now confirm that your amendments have been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and also that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Yours sincerely,

Professor M J Wilkinson
Chair
FMH Research Ethics Committee

Appendix O – University of East Anglia Faculty of Medicine and Health Sciences Research Ethics Committee Protocol Amendment Approval

Faculty of Medicine and Health Sciences Research Ethics Committee

Paul Workman
MED

Research & Innovation Services
Floor 1, The Registry
University of East Anglia
Norwich Research Park
Norwich, NR4 7TJ

Email: fmh.ethics@uea.ac.uk

Web: www.uea.ac.uk/researchandenterprise

1 November 2018

Dear Paul

Project title: The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser

Reference: 2017/18 - 121

Thank you for your e-mails notifying us of the amendments you would like to make to your above proposal. These have been considered and we can now confirm that your amendments have been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and also that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you also arrange to send us a report once your project is completed.

Yours sincerely,

Professor M J Wilkinson
Chair
FMH Research Ethics Committee

Appendix P – Participant Demographic Questionnaire

University of East Anglia Doctorate in Clinical Psychology

The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser

Questionnaire

Thank you for participating in this research. I would now like to ask you a few questions.

Please indicate your age:

Please indicate the opiate that you use (e.g. methadone):

Duration of your current couple relationship (e.g. 12 months):

Please indicate your relationship status (e.g. married, long-term relationship):

Please indicate the main substance that your partner uses:

Do you wish to receive a copy of the transcript from the interview? Yes / No

If yes, please indicate the postal or email address you would like this to be sent to:

Do you wish to be kept informed of the results of this research? Yes / No

If yes, please indicate the postal or email address you would like this to be sent to, if different from above:

Thank you for your participation in this research

Appendix Q – Interview Topic Guide

- Orientation
    - Introductions, what study is about
    - Opportunity for additional questions
    - Completing demographic questionnaire

[Recorder turned on]

- History of relationship and substance misuse (Introductory Questions)
    - When met – *'Can you tell me how/when you first met your partner' 'What was that like?'*
    - Significant life transitions (marriage, children) – *'As a couple, have you been through or experience any significant life events/changes?'*
    - Type of substance use current and past – *'Can you tell me about your use of opiates in the past' 'Can you tell me about your current use of opiates?'*
    - Course of substance use – chronicity, relapses? – *'What has the course of your use of opiates been like?' 'What has it been like to try to reduce in the past?'*
- Treatment Experience
    - Experience of initial help seeking (if any) – *'What was it like to start to look for help in reducing your drug use?' 'What led to you wanting to seek help?'*
    - Experience of starting treatment with services – *'How did you find starting treatment?' 'What were the first few meetings like?' 'How did they go?'*
    - Attitudes towards treatment in early stages – *'What did you think of your treatment when it first began?'*
    - Experience of substance reduction in general – *'What has it been like for you to reduce your drug use?' 'How have you managed this?'*
    - Experience of substance reduction whilst in proximity to partner

        - Attitudes on relationship impact on treatment – *'How do you think your relationship has impacted on your treatment?' 'What has been difficult?' 'What has been helpful?' 'What has been unhelpful'.com*
        - Impact on the relationship – *'How has your treatment for drug use impacted on your relationship?' 'Have you noticed any difference in your relationship whilst in treatment?'*
        - Details of impacts
        - Meanings about relationship
    - Relationship adjustments
        - Partner's Attitudes to treatment – *'What do you think your partner thinks about your treatment for drug use?' 'Have they said anything about their thoughts on your treatment?'*
        - Support for relationship received? *'Have you and your partner received any support for your relationship?'*
    - Satisfaction with treatment and support – *'So far, how satisfied are you with your treatment and support?' 'What has been good about it?' 'What has been unhelpful about it?*
    - Impact on the self
        - Support offered from partner – *'What support has your partner offered your or provided you with based on your treatment?'*
        - Changes to attitudes on treatment and recovery – *'Over the course of your treatment, how have your thoughts on treatment for drug use changed?' 'What have your thoughts on what long-term recovery means for you?*

- Experience of interview (Closing Questions)
    - Anything not covered

[Recorder off]

- Questions from participant
- Debriefing

Appendix R – Participant Debrief Sheet

University of East Anglia Doctorate in Clinical Psychology

The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser

Thank you for your participation in this research. The information you have shared will allow a greater understanding of the experience of being in treatment for substance use whilst in a relationship with another substance user.

Your data will be anonymised, and your information kept confidential. Data will be used in submission towards the researcher's doctoral thesis in the University of East Anglia Clinical Psychology Doctorate Programme. Data and individual anonymised quotes may be used in academic research publications.

Should you wish to discuss further your participation in this research project you may contact the researcher, Paul Workman on XXXXX

Your GP and other NHS services may be able to provide support regarding feelings around substance misuse.

Further support on substance misuse can be obtained from:

NHS Choices – http://www.nhs.uk/Livewell/drugs/Pages/Drugshome.aspx

Talk to Frank - http://www.talktofrank.com/

Samaritans - http://www.samaritans.org/ or Freephone 116 123

Support for couple relationship difficulties may be accessed from:

Relate - www.relate.org.uk, or by calling 0300 100 1234.

The Couple Connection - www.thecoupleconnection.net

Appendix S – Third Sector Organisation Approval

May 2018

Dear Paul Workman,

The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser

As requested this letter is to confirm that your research application named above has been approved by [redacted] versight Group.

As advised by [redacted] xecutive Medical Director and chair of the research oversight group.

Also note that we will seek progress reports from you at various times during the course of your research project. A copy of this progress report will emailed to you along with this letter for your information. We 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 us

Thank you for considering us for assistance with your research and Good Luck with the study.

[redacted]

Executive Medical Director [redacted]

Appendix T – Key Worker Pro Forma

Norwich Medical School
Postgraduate Research Office
Elizabeth Fry Building
University of East Anglia
Norwich
NR4 7TJ
E: XXXX
T: XXXX

Guide for clinicians discussing the research study with patients.

The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser

Dear XXXX Clinicians,

Thank you for taking the time to consider whether this research project is appropriate for your service users. This research aims to explore the lived experience of service users engaging in support in the XXXX for opiate dependency whilst also being in a close relationship with another opiate user. The participant information sheet provides detailed information about the study. This letter aims to highlight the key points that might be relevant to explain the research to each patient so they can decide if they want to receive further information.

Inclusion and exclusion criteria:

To be included in the study, participants must:

- Participants aged 18 and over,
- In contact with and receiving treatment from services for opiate drug use.
- Participants will be recruited at any stage of XXXX treatment
- Married or in an enduring close personal relationship of at least 12-month duration with another substance misuser who is not in contact with treatment services.

Patients cannot participate if according to your clinical judgement:

- Unable to provide informed consent to participation in the study,
- If problem alcohol use or drugs other than opiates are the primary substance focus of treatment.

Information you may wish to discuss with patients:

- The research project aims to explore the participants lived experience of engaging in treatment whilst in a relationship with another opiate user.
- The researcher and research project are not connected to their hospital or treatment and the client does not have to take part if they do not wish to.
- Declining to take part will not affect their treatment in any way.
- It is hoped that by exploring this area better the research can help inform future support in substance misuse services.
- There is a Participants' Information Sheet, which details the research for the participant. All participants will need to read this before taking part. I will answer any questions and discuss everything they need to know to consent to being part of the research.

- I am the chief investigator for this project, which is being done as part fulfilment of the Doctoral Programme in Clinical Psychology at the University of East Anglia.
- Taking part would mean meeting with me for approximately 60 to 90 minutes. At the meeting, I would go through the study consent process, ask the participant some brief demographic questions and then complete an interview with them.
- They will receive a £20 'Love2Shop' voucher for their participation. This can only be provided for participants that complete interviews.
- This research project has received University of East Anglia ethical approval and has been reviewed and approved by the XXXXXX Research Department.

The next steps are:

- Please consider people on your caseload who might meet criteria for this study.
- At your next clinical meeting with them, tell the patients about the study and give the patients a copy of the enclosed Participant Information Sheet.
- During your discussion, if they are interested in the study, please give them a copy of the Consent to Contact sheet to complete with you.
- Inform them that I will be in contact with them on the details they provide on the Consent to Contact sheet to arrange a meeting to discuss the study further.
- Please inform me via email on XXXXX that you have a completed Consent to Contact sheet and I will come to the XXXX to collect this.

Thank you for taking the time to read this and for supporting this research project. If you have any questions or queries please do not hesitate to contact me.

Paul Workman
Trainee Clinical Psychologist
University of East Anglia

University of East Anglia

Are you in a relationship with another substance user whilst getting treatment for your own opiate drug use?

- Research exploring impact of being in treatment for opiate use in a relationship with another opiate user
- Help develop understanding of experiences
- Data used in anonymous format
- Participants to be aged 18+, receiving treatment for opiate use, and in current relationship (+12months or married) with another opiate user who is not currently in treatment for their drug use.
- Interviews last 60 – 90 minutes
- Participants will be provided with £20 supermarket vouchers
- Interviews conducted by Trainee Clinical Psychologist, attending University of East Anglia Doctorate in Clinical Psychology
- Call Paul Workman (researcher) for more information – XXX

Appendix V – Participant Information Sheet

University of East Anglia

Participation Information Sheet

University of East Anglia Doctorate in Clinical Psychology

The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser

Invitation and brief summary

I would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being carried out and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

The aim of this research project is to find out the experience of being in treatment for opiate drug use whilst also being in a relationship with another opiate substance user. This research will explore your treatment and recovery in the context of your partner's drug use. This can be a past or present relationship.

Who is running the study?

This study is being run by Trainee Clinical Psychologist, Paul Workman as part of his Doctorate in Clinical Psychology at the University of East Anglia (UEA). This will be under the supervision of Dr Caitlin Notley, Senior Lecturer in Mental Health, within the Faculty of Medicine and Health Sciences at UEA.

Do I have to take part?

Participation in this study is voluntary and entirely up to you whether you take part or not.

What would taking part involve?

The study involves taking part in an interview with the researcher (Paul Workman) to discuss your experiences of treatment for opiate use whilst in a relationship with another opiate user. All interviews will be audio recorded and will take place at the XXXXX centres or at your home.

The interview is expected to last between 60 and 90 minutes. You will be asked questions about your relationship and treatment. The interview will be audio-recorded to aid data collection. Following this, you will be asked to complete a short demographic questionnaire that may take around 5 minutes to complete. All participants taking part in the interviews will be provided with £20 'Love2Shop' vouchers.

If you wish to participate in the study, you can either contact the researcher directly or discuss it with your key worker. Once you contact the researcher to express your interest, we will arrange a meeting with you to discuss the study and you will have an opportunity to ask any questions you may have.

During this meeting, if you still wish to participant in this study and the researcher agrees that you meet the criteria for the study, you will complete a consent form to participate. The interview will then be undertaken.

Your participation in this research project is voluntary. You may choose to not answer questions, and additionally may choose to opt out at any stage during the interview. Following the interview, you will have the option to request a copy of a transcript of the interview. Additionally, all participants are free to withdraw from the study at any point during or up to the point of data analysis after the interviews. This research has been approved by the NHS Health Research Agency.

Your treatment will not be affected by involvement in this research project.

What are the possible benefits of taking part?

This research provides a unique and non-clinical space to discuss experiences of your treatment and relationships. By participating, you will also be contributing to the knowledge base of an under-represented group in research and society.

What are the possible disadvantages and risks of taking part?

Participating in this study you are required to provide a large amount of your own time. In an attempt to reduce burden as far as possible, you will be offered the opportunity of breaks in the interview. Refreshments (water, tea, coffee & biscuits) will be provided during the interview

Each participant will be offered a £20 'Love2Shop' voucher as a reimbursement for your time in taking part in the interview.

At the end of the study, you will also be provided with an information sheet which will contain information on counselling and support services which may be of use to you.

Will my taking part in the study be kept confidential?

Your information will only be used for the purposes outlined in this Participant Information Sheet. Data management will follow the Data Protection Act (1988) and the University of East Anglia policy. Once your interview has been completed, the audio recording will be uploaded onto a secure, encrypted system on UEA secure servers. All audio recording will be transcribed by the researcher, Paul Workman.

All data will be stored in secure sites accessible only by the research team within the Medical School in the University East Anglia, as per University of East Anglia's policies. Electronic information (audio recordings and transcriptions) will be kept on a password protected files on UEA secure servers after it has been transferred by encrypted memory. All audio recordings will be transcribed within 2 weeks of completing the interview. When transcription is completed, the audio file will then be destroyed. In line with the Data Protection Act (1988), transcripts and all anonymised data will be kept for 10 years following the end of the study. After 10 years, they will be destroyed.

Only the researcher will be able to identify interview data that belongs to you. Your participation and information given during the research process will not be shared, unless concerns are raised about your own, or someone else's safety. You will be informed in advance should this be necessary.

The information collected during this research study will be used in an anonymised format. Your data will be used with that of other participants to produce written reports and submitted for submission as part of the researcher's doctoral thesis submission. This research may be submitted for publication in academic journals. Potentially, interview material may be used to support the development of resources to support others in similar situations – again, this will be in an anonymised format.

If you have any questions or comments about this research, please direct them to the researcher.

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do his best to answer your questions on the number provided below. If you remain unhappy and wish to complain formally, you can do this through the NHS Health Research Agency complaints procedure. Details can be obtained from the University, or by visiting
http://www.hra.nhs.uk/resources/raising-concerns-about-our-services/

What will happen if I don't wish to carry on with the study?

If you take part in the study and then decide to withdraw your data later, it may be possible to withdraw your consent at any time up until the analysis of the data begins in September 2018. If you decide to withdraw from the study, you can contact the researcher, Paul Workman on the details below. Your interview responses will be deleted and not included in any part of the analysis and report write up.

Who had reviewed this study?

Before any research goes ahead in the NHS, it needs to be checked by an independent panel called the Research Ethics Committee. This is make sure that any research conducted is ethical and to protect the safety, rights, wellbeing and dignity of participants. This study has been reviewed and was given a favourable opinion by HRA and also approved by the Faculty of Research Ethics at UEA.

Deciding to participate in the research

If you would like support in deciding whether or not to participate in this research project, you may wish to discuss this with your partner, friends, or family. The researcher, Paul Workman, will be able to answer any questions you have about the research.

Contact details

When you have read this participant information sheet, you can contact the researcher to ask any questions you may have, and arrange a meeting at X or at your home. The researcher, Paul Workman can be contacted on the following telephone number (X).

If you are concerned about the way this study is being conducted or wish to make a complaint to someone independent from the study, please contact:
Professor Richard Meiser-Stedman
Professor of Clinical Psychology
Faculty of Medicine and Health Sciences
Univesity of East Anglia
Norwich NR4 7TJ
R.Meiser-Stedman@uea.ac.uk

Appendix W – Consent to Contact Form

University of East Anglia

CONSENT TO CONTACT FOR RESEARCH PURPOSES

The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser

The aim of this research project is to find out the experience of being in treatment for opiate drug use whilst also being in a relationship with another opiate substance user. This research will explore your treatment and recovery in the context of your partner's drug use.

I am conducting research to explore this experience in greater depth through interviews. These interviews will be recorded and will last for between 60 and 90 minutes and can be arranged at a time to suit you. All participants taking part in the interviews will be provided with £20 supermarket vouchers. All information given will be kept anonymously and will be used as part of a doctoral thesis submission and may be published in an anonymous format. This research has been approved by the UEA Faculty of Medicine and Health Sciences.

You are being invited to give consent for myself, Paul Workman, to contact you discuss your potential participation in this research study.

Are you willing to learn more about this study? (Circle one)

YES NO

If yes, you will be contacted at a later date. Please include your contact information below.

Contact Number:

Participant Signature: _____

Date: _____

Yours faithfully,

Paul Workman
Trainee Clinical Psychologist

Appendix X – Consent Form

University of East Anglia Doctorate in Clinical Psychology

Consent form

The Experience of Treatment for Substance Misuse whilst in a Close Relationship with another Substance Misuser

Name of Researcher: Paul Workman

Please initial box

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected.	
I consent to my interview being audio recorded.	
I agree to my data being used, including individual quotes, in an anonymised format for submission towards the researcher's doctoral thesis. I understand that this thesis may be subsequently published in other formats in academic journals or support literature.	
I wish to receive a summary of the study findings, once the project has been completed.	
I understand that responsible individuals, from the University of East Anglia may look at sections of my medical notes where it is relevant to my taking part in research. I give permission for these individuals to have access to my records	
I agree to take part in the above study	

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix Y – Coding Example

Participant Line Number	Emergent Themes	Original Transcript	Explanatory Comments
Yvonne (pseudonym) 244-286	Relationship as an influence on her heroin use Formulating her move toward abstinence Undermined relationship bond	**Yvonne:** Yeah it does, I probably wouldn't touch it at all if he wasn't. The only time I would touch it at all is if I've smoked a lot of crack and then I'm left feeling edgy and then I feel like I need a bit of heroin to bring me down, but other than that I don't really think about the heroin other than when I see [partner] injecting, or sometimes when he smokes a pipe, but now I don't really like the taste of it, I'll have the odd pipe because I've stopped injecting, which is good, I've stopped injecting completely, so I'll have the pipe but I detest the taste of it, so that's only when I really, really feel I need one, but other than that I don't feel like I need it at all. My aim is to give a clean sample of heroin next week, because I've cut that right back, so basically just when I see him do it, and I think oh I want one, but no it's not because I need it, you know, so yeah (pause) **Interviewer:** How does, your use of treatment and wanting a clear sample, how does that impact on the relationship? **Yvonne:** Erm, he wants me to give a clean sample. But I think sometimes, he'll say 'you're not having any of this, you've got to give a clean sample and that'll look really good, I'm really pleased' and I think, one minute I think yeah he's supporting me but then a part of my, something creeps in and I'll think he's only saying that because he doesn't want to share it, and it's like I'll be getting paranoid a lot about things, and I'll be flip siding everything. Yeah I think he would like to see me not using and give a clean sample **Interviewer:** Ok you were saying there that [partner] wants you to stop using and in one way is supportive and the other you thinking why is he wanting me to stop using, what do you make of that?	Sense of partner being main influence in her drug use but also use of crack. Rationalising continued drug use through change in method. Internal conflict of wanting but differing perspective on not 'needing it' Shift in perspective on drug taking? Liner perspective on recovery – 'cut right back' now to give a clean sample. Does progress enable self-efficacy and perspective of not needing heroin? First statement is on what partner wants from her treatment. Partner perspective important to her? Paranoia, flipping perspectives. Naming both perspectives Naming paranoia places misinterpretation back on her. Holding two perspectives. Allowing a perspective that protects the relationship?

	Relationship destabilised Conflict over treatment Empathy for partner position Recovery destabilising relationship future	**Yvonne:** Yeah, is it because he wants it all to himself or is it because he wants me to give a clean sample and get better, yeah. **Interviewer:** What do you think about you being in treatment and on a maintenance treatment, and [partner] not at the moment? ***Yvonne:*** *Erm, (pause) at first he was saying that he was going to get on a script too so that we'd be on the same page, but it hasn't turned out like that obviously, we've had a few arguments about it. Then he kept saying that he would do and go to [service provider] but I do know what it's like waking up poorly and processed you've got money there, it is easier to say, you know, I'll just get a bit of gear and go up tomorrow but this tomorrow never comes. I'm hoping that he'll either get clean on his own and he'll not be on a script, I think it would be quite hard for him to do, I really can't see him, I don't know, I, unless he's not using as much he can get up to [service provider] you know if he feels well enough in the morning, because at the minute he's too ill and if he's got the money he'll just buy heroin and say I'll go tomorrow, erm, but I'm hoping that, because I don't know how it'll go if I'm staying clean, and sticking to what I need to be doing and he carries on using, I really don't know how it's going to go. Because we'll be on different pages, you know, going in different ways so I really don't know. I don't think it'll last, but I don't know, I really don't.*	'Same page' sense of relationship unity or shared experience, which isn't actualised when he is not in treatment? Issue of conflict and arguments around partner entering treatment. Rationale offered immediately as to why he doesn't, empathises with partners position. Justifies him not being in treatment. Contradiction of partner influencing and supporting her treatment and him not being influenced in the same way? 'Sticking to what I need to be doing' working toward an individual goal, sense of divergence in relationship. Uncertainty of the future of the relationship – related to; 'we'll be on different pages'. Metaphor of differing trajectories.

Appendix Z – Master Table of Themes

Superordinate Themes	
Rationalising the Relationship *Romanticising* Vicky: On the streets, we met with nothing. Which is the best way to meet because there's none of this, 'Oh look at my big house, my car, my big bank account' (laughs) Kate: um it has it's ups and downs. It's strong, happy, loving, like I said it has it's ups and downs, but yeah good Yvonne: I just remember he was a real gentleman compared to everyone else. You know, because I've always been someone who is old fashioned in what I believe you know, you don't sleep with someone before you get with them, things like that. That's what stood out for me about him, he was very similar to me in values, he had the same values as me Tom: Erm, well it was great, I sort of, the minute I set eyes on her, I knew *Uniqueness of Us* Tom: We're a very strong couple, it's unusual in this sort of small percentage of society of addicts, it's very usual for people to stay together Yvonne: I do think that like with a lot of addicts, you know, the relationship is built solely upon that the drugs, so if you took the drugs away then you've got two people you have got nothing in common, they've no similarities, they don't share any interests, it's solely drugs and the need and sometimes the greed for them. You know, erm, but I do know that with [partner] and I there is more than drugs Vicky: It's been good, like I say we both started with nothing, we were both on the streets so we built ourselves up	
Negotiating Treatment *Partner Influence* Sarah: I do enjoy a smoke with him, it's like someone having a glass of wine at the end of the day, that's the way I look at it because I've done it for so long, it's something that we enjoy Kate: You can be triggers for each other Tom: Just, you know what the term setting each other up means? You, sort of you know, say erm, I'm doing well and I might see [partner] have something and it might make me think about having something, you know, I might do. I'm painfully aware of that sort of thing. Yvonne: I don't really think about the heroin other than when I see [partner] injecting	

Formulating Recovery Tom: I've been clean before and then sort of relapsed, but it's always my goal to be totally clean, you know Kate: I'm quite happy where I am at the minute because I'm steady, I'm doing really well at the moment. I'm working, I'm doing some more training at the moment with the company next week and erm, so but eventually I'd like to be off everything Sarah: I'd love to say you know, I'm never going to do it again but I'd be lying you know, I enjoy it, I enjoy once every couple of months or once a month I enjoy spending a little bit of money and I enjoy doing it. I think I'll always be like that, but I can't see at the moment, it's me getting over the I enjoy doing it bit, I think	
Identity Dissonance *Identity Shift* Kate: You waste your money, you feel rubbish about yourself, you feel dirty, guilty. Ashamed. And you sort of tend to isolate yourself from people, you feel that everyone knows, even though they probably don't (laughs). I hate it. It's taken so many years of my life you know, I wasted so many years that I could have had a relationship with my mum so, my brothers because of it. I could never get that back and that's all because of heroin. It's just shit (laughs) generally Tom: I've learnt that I can't always do that. I need to share it a bit. It's just that sort of macho, stereotype type, caveman type (laughs) that been around for years and I try not to be like that. Vicky: it sounds really bitchy but I was looking at other people who were doing it and thought (laughs) you scum bags, I'm better than you *Self as addict* Yvonne: But then that is just crazy because I'm in treatment and I'm stable and, but that's just insane thoughts, it's, that's what being an addict is Tom: Erm well, I'm just not, I knew it wouldn't lead to sort of like happiness you know, it wasn't going to benefit me, but I'm an addict so it was hard Vicky: I've always had an addictive personality, I was a speed freak years ago, I was addicted to speed for years. And then I come of speed and was addicted to pro plus, just something. And then I was only smoking gear on the pipe and then started injecting and the buzz was better (Interviewer: OK) and then you start having snowballs, which is with the crack, and wow (laughs)	

Re-evaluating the relationship *Differing directions* Yvonne: It'll be really hard to stay together because we'll be going in different directions, and it (exhale of breath) if I'm clean and doing well I won't want him using, you know, it would be putting my recovery in jeopardy Sarah: our intimacy at the moment isn't very good, that's the main part what isn't very good (Interviewer: Okay, okay) but I'm not too worried and I know that sounds bad but I'm not really too worried about it. It's not something, because I've had so much on my mind with coming off the gear, you know and my using down *Relationship discord* Vicky: it's frustrating and I want him to get into treatment and oh my god how many times he's said, yes yeah I'll come, yeah I'll come in, and he don't, but like that's hard because he gave me the ultimatum and I done it (pauses) but I can't give him the ultimatum back. Sarah: He might get a bit shitty with me in the morning because of how he's feeling, and I'll be alright because I've got enough methadone Yvonne: at first he was saying that he was going to get on a script too so that we'd be on the same page, but it hasn't turned out like that obviously, we've had a few arguments about it	