Ways of Coping in Male Partners of Female Problem Drinkers

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I am grateful to many people for their assistance in the completion of this thesis.

A huge thank you to all the members of the community alcohol teams who helped in the recruitment of the participants.

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And finally thank you to those people around me who have supported me over the last three years.
ABSTRACT

Despite there being a significant amount of literature and research studies looking at the ways family members cope when they have a relative who has a substance use problem (e.g. Hurcom et al., 1999; Orford et al., 1992; Orford et al., 1998) very little is known about male relatives and no research has been carried out specifically looking at the coping behaviours of male partners of female problem drinkers.

The current study aimed to look at the reported coping behaviours of a sample of male partners of female problem drinkers, to examine some of the factors that have been associated with coping (Lazarus & Folkman, 1984), and to compare the coping behaviours of the male partners with a sample of female partners from another study (Hurcom et al., 1999; Orford et al., 1998).

The study recruited 28 male partners and coping behaviours were measured using the Coping Questionnaire (Orford, 1996). The study found that the male partners reported using a range of coping behaviours, and in particular significantly less withdrawal coping behaviours than the comparison female partner sample.

The study also found that there was a significant positive correlation between how much of a problem the male partner saw his female partner’s drinking and his use of tolerant coping behaviours. A significant positive correlation was also found between the duration of the female’s drinking problem and the male partner’s use of both engaged and tolerant coping behaviours.

The results suggested that male partners were affected by their female partners problem drinking and that services should be more active in engaging male partners. This is seen as important in terms of providing support for the female problem drinker’s treatment and helping to lessen the male’s experience of stress. The study found differences in the ways that male and female partners cope, but questions were raised about whether age and relationship stability may be more significant factors than differences in gender.
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The role of family members

In a review of studies evaluating treatments for alcohol problems, Miller and Wilbourne (2002) found that among those with the best evidence were treatments that included the client’s social support network. Provision of social support is seen as coming from those people close to the person with the substance use problem, such as family, friends and work colleagues (Copello, Orford, Hodgson, Tober & Barrett, 2002; Longabaugh, Wirtz, Zweben & Stout, 1998) and it has been found that family members can support problem drinkers and be a positive influence in their attempts to cut down their alcohol consumption (Holmila, 1994; Sobell, Sobell, Toneatton & Leo, 1993).

Amongst family members, spouses in particular have been thought to play an important role in the remission of their partner’s drinking problem and in preventing subsequent relapse (Collins, 1990; Orford, Oppenheimer, Egert, Hensman & Guthrie, 1976; Sobell et al., 1993). Brennan, Moos and Kelly (1994) found that supportive behaviour by a spouse led to a better outcome, and being married has been considered as a protective factor. Bromet and Moos (1976) found that in a sample of male and female problem drinkers, those who were married had significantly better scores on measures of psychological and physical symptoms such as anxiety, depression and physical impairment.

The impact on a person of having a close relative with a drinking problem can be considerable. The family directly experience the consequences of the drinking
behaviour and coping with this may produce a variety of psychological and social reactions (Collins, 1990). Moos, Finney and Gamble (1982) found that wives were emotionally and physically affected by their partner's drinking and Brennan et al. (1994) found that at the point of referral, spouses of problem drinkers were significantly more depressed, had more physical symptoms and engaged in fewer activities with family members than spouses of non-problem drinkers. Roberts and Brent (1982) found that relatives of people with alcohol problems were not only more likely to visit their doctor, but had higher rates of stress-related diseases. Therefore, as well as supporting and having an influence on the problem drinker's treatment, family members are seen as needing support, and researchers have developed ways of working with the specific needs of family members which aim to reduce their experience of stress (Copello, Orford, Velleman, Templeton & Krishnan, 2000; Copello, Templeton, Krishnan, Orford & Velleman, 2000; Halford, Price, Kelly, Bouma & Young, 2001).

An historical view of families

Over time the literature concerning families of people with substance misuse problems has focused on different hypotheses. Much of this literature, and many of the associated research studies, have concentrated on the wives of male problem drinkers and only in recent years has research included other family members such as male relatives, parents and siblings (e.g. Orford et al., 1992).

The disturbed personality hypothesis

Early research with families of people with alcohol problems sought to describe the personalities and types of women married to men with a drinking problem (Rae, 1972;
Whalen, 1953) in an attempt to answer the questions as to why they married problem drinkers and why they stayed married to them (Watts, Bush & Wilson, 1994). It was suggested that wives chose to marry heavy drinkers to meet the needs of a ‘dysfunctional’ personality. This idea was based in psychodynamic theory and saw wives of problem drinkers as having neurotic conflicts that were resolved by marriage to a problem drinker. It was felt that if the male stopped drinking, the woman’s defences would be removed and she would sink to a more severe pathology (Cronkite, Finney, Nekich & Moos, 1990). Inherent in this approach was a blaming of the wife for the role she played in the development and maintenance of her partner’s drinking problem. These ideas were later criticised as they had not been empirically tested (Edwards, Harvey & Whitehead, 1973; Watts et al., 1994), wives had been observed when the husband’s drinking was at a severe level and no observations or reference was made to the time prior to the development of the drinking problem (Edwards et al., 1973).

The stress perspective

In contrast to the disturbed personality hypothesis, Jackson (1954) saw the behaviours exhibited by wives of problem drinkers, as a product of the similar experiences of stress produced by living with someone with an alcohol problem. Previously the wives' behaviour had been seen as dysfunctional, but Jackson felt it was only dysfunctional if considered in terms of what was best for the person with the alcohol problem. In the context of the family, she suggested that the wives' behaviour may have helped to stabilise an otherwise chaotic and disruptive situation. These ideas led to the stress hypothesis that saw pathology in spouses as a reaction to the stressful situations in which they found themselves.
Research findings do support the idea of stress induced symptoms. For example, Moos et al. (1982) found that spouses of problem drinkers exhibited levels of depression, anxiety and physical symptoms not seen in spouses of non-problem drinkers. These symptoms were seen as tied to the drinking behaviour, as no differences were found between the group of spouses of non-problem drinkers and a group of spouses of problem drinkers who had stopped drinking. This finding also challenged the idea that a wife would sink to a lower level of functioning when her partner controlled his drinking (Cronkite et al., 1990).

**A family systems model**

One of the key principles in family systems models is the idea that when a crisis or stressful event occurs, family members try to maintain a homoeostasis within the family unit (Carr, 2000). Steinglass (1979a) described an interactional systems model where the problem drinker was the labelled or identified patient, whose behaviour expressed the distress and needs of the entire family. This model suggested that the family problems that underlie the drinking would remain even if the problem drinking stopped and that the problem drinking was maintained by the family as it played a function and helped to retain some stability (Steinglass, 1979b). In this model, the blame for the continuing drinking problem was put on the entire family and some form of family therapy was seen as the way to treat the alcohol and underlying problems. However, Collins (1990) concluded that there was a lack of research evidence for the use of family systems approaches with people with alcohol problems.
**The co-dependency concept**

The concept of co-dependency emphasises the family’s attempts at controlling the problem drinker’s behaviours and developed from the 12 steps model of Alcoholics Anonymous (Holmila, 1994). Although there is little agreement on a definition, it sees the family members’ behaviours and beliefs as dysfunctional, and by adopting the disease model of alcoholism, sees those with a ‘co-dependency’ as sick (Hands & Dear, 1994). In a critical review of the co-dependency literature, Hands and Dear suggested that many of the characteristics of co-dependency overlapped with the cultural expectations of women, and therefore that although both men and women could in theory be described as co-dependent, the concept mainly described female relatives’ behaviour. Women are traditionally seen as carers and are trained via societal norms to meet the needs of others, and co-dependency is seen as pathologising these caring behaviours (Hands & Dear, 1994). Like in the disturbed personality hypothesis, wives are seen as being responsible for their husband’s drinking and the assumptions of blame and responsibility are among the most criticised aspects of the co-dependency concept (Miller, 1994).

**Stress and coping approach**

This approach focuses on the stress caused by having a family member with a substance use problem and the behaviours that the family use in an attempt to cope with the problem. The application of the stress and coping approach to alcohol problems emerged at a time when there was considerable interest in these concepts in the general literature (e.g. Lazarus & Folkman, 1984) and was seen as a move away from ideas where family members were blamed for the problem drinking (Hurcom, Copello & Orford, 2000). The stress and coping approach does not seek to explain the
cause of the problem drinking, but sees the way that the family tries to cope as having a role in the future course of the problem (Orford et al., 1992). This approach to thinking about the experiences of family members of problem drinkers has lead to a great deal of recent research (e.g. Brennan et al., 1994; Holmila, 1994; Hurcom, Copello & Orford, 1999; Orford et al., 1998).

Male partners – a neglected group

Where support for the different hypotheses described above was based on research findings, these were predominantly studies looking at wives of male problem drinkers. In some cases it was assumed that the theory would apply equally to male partners of female problem drinkers (e.g. the co-dependency concept, Hands & Dear, 1994), and in others that male partners were not a group deserving of attention. For example, Whalen (1953) stated that male partners represented less than one in fifty of the relatives seen in treatment services. Therefore despite the significant amount of research looking at families, little remains known about male family members.

Research has often focused on spouses, but there has been little research aimed specifically at male partners of female problem drinkers (Orford et al., 1998). Where information on male partners is presented, it is often anecdotal or of a single case study (e.g. Dinaburg, Glick & Feigenbaum, 1977). Pérudeau (1994), in a review of the literature on female married problem drinkers, stated that there were limited reports of male partners and that the few that existed were predominantly based on the subjective accounts of the female problem drinkers. When family members other than wives have been included in research studies, there tend to be few male relatives (e.g. Sisson & Azrin, 1986; Yates, 1988). Where male partners are included these are often
fathers of substance users and the numbers are often not large enough for meaningful comparisons to be made (e.g. Orford et al., 1998).

A paucity of research in this area may be due to the comparatively small number of affected male partners. Research suggests that of those seen in treatment services, male problem drinkers out-number female problem drinkers (Plant, 1997; Waterson, 1996). This in turn would mean that there are less male partners affected by a partner’s problem drinking, but research suggests that these figures may be changing, and the number of female problem drinkers now being seen in treatment services is converging with that of male problem drinkers (Waterson, 1996).

In a report of a service designed specifically for those affected by the drinking of a family member, Yates (1988) found that most people who accessed the service were female and concluded that this reflected the fact that females were more often the victim of someone else’s drinking. But Sternbach (2003), writing about self-disclosure in all-male therapy groups, suggested that culturally, men are not expected to display emotional honesty, dependency or vulnerability and that male socialisation is organised around competition, emotional distance and disconnection. These ideas suggest that men would not willingly seek support to help them cope with their female partner’s drinking. There is some support for these ideas in that husbands have been found to deny their wife’s drinking problems (Curlee (1967), as cited in Pérudeau, 1994). Therefore the fact that Yates (1988) found more women approaching his service could be explained by the fact that women find it more acceptable to seek help from such a service, and therefore are more likely to be represented in such self-selected samples.
The dearth of research looking at male partners is reflected in the fact that compared with those looking at male problem drinkers, there are few studies that focus on female problem drinkers (Wilson, 1980). Miller and Wilbourne (2002) found that in the 361 clinical trials they reviewed whilst evaluating treatments for alcohol problems, 84% of participants were male problem drinkers. This was despite there being evidence that males and females respond differently to treatment (e.g. Cronkite & Moos, 1984; Miller & Wilbourne, 2002; Pemberton, 1967; Sanchez-Craig, Spivak & Davila, 1991). Taking into account the greater numbers of male problem drinkers who present to services (Plant, 1997; Waterson, 1996), it may be assumed that it is easier to study male problem drinkers and in turn their female partners.

There is some suggestion that the lack of research looking at male partners of female substance users may be due to difficulties in recruiting participants. Laudet, Magura, Furst, Kumar and Whitney (1999) looked at the attitudes of male partners of females receiving treatment for cocaine use. They stated that there was a lack of willingness of male partners to be involved in the research and suggested a difficulty in identifying and engaging male partners.

It may also be assumed that separate research is not necessary as male partners will respond to problem drinking behaviours in the same way as female partners. For example, Moos et al. (1982) looked at subgroups of their sample to compare partners of male drinkers and partners of female drinkers. The two subgroups were matched by demographic data and they found no differences on seven variables which included active behavioural coping, active cognitive coping and avoidance coping.
There are several suggestions as to why specific research has not been carried out looking at the coping behaviours of male partners of female problem drinkers, but assuming that they will cope in similar ways to female partners of male problem drinkers seems unfounded, especially as gender differences in coping behaviours have been reported.

**Gender differences in coping**

The majority of the studies looking at the coping behaviours of family members of people with a substance use problem have focused on female relatives and where male relatives have been included, gender differences are generally not reported (e.g. Orford et al., 1998). One of the only references to gender differences is made by Orford et al. (2001) who found that husbands of female problem drinkers had the highest withdrawal coping scores of all the relatives in their study, where withdrawal coping is seen to include avoidant behaviours and behaviours that indicate an independence from the problem drinker (Orford et al., 1998). This finding was based on a small number of male partners and for all male family members, the scores on the withdrawal coping scale were almost identical to those of female family members. Therefore it is unclear if this finding would be replicated with a larger sample of male partners.

Beyond this, one has to look further than the literature focusing on alcohol problems to find evidence of differences in the ways that males and females cope. A series of research studies found differences in the way that mothers and fathers coped when they had a child with a chronic illness (Eiser & Havermans, 1992; McCubbin et al., 1983; Powers, Gaudet & Powers, 1996). Mothers found social support and seeking
information most helpful and fathers found being autonomous most helpful. In these studies coping strategies were rated on a scale from ‘not being helpful’ to ‘extremely helpful’, and it is unclear whether parents had actually used these methods of coping, or thought that they would find them helpful if they did use them. The gender differences described could be explained by the different parental roles in the family and in the relationship with the child, therefore differences may not extend to males and females coping with a partner who has an alcohol problem.

Billings and Moos (1984) reported that in coping with depression, females used more coping behaviours that were seen as providing a discharge of emotions (i.e. verbal or behavioural expressions of unpleasant emotions and indirect efforts to reduce tension, such as eating or smoking more). This study looked at how people coped with their own depression, so the gender differences may not translate to partners coping with someone else’s behaviour.

Gender differences have also been reported in the general literature on coping. Folkman and Lazarus (1980) in an analysis of coping in a middle-aged community sample found that men used more problem-focused coping in situations seen as having to be accepted or as requiring more information. Problem-focused coping was seen as active coping that aimed to change an aspect of the situation and the authors suggested that men may persevere with problem-focused coping longer than women before deciding that nothing can be done. Therefore it could be suggested that a sample of male partners would be expected to show higher levels of problem-focused coping when compared with a sample of female partners of problem drinkers.
Whether the gender difference in coping reported by Folkman and Lazarus (1980) extends into the way that someone copes when a partner has an alcohol problem remains to be shown, but there are several factors which suggest that gender differences might be expected. One of these relates to the social and cultural attitudes that are held about alcohol and drinking behaviour.

**Social and cultural influences**

Researchers writing from a sociological perspective suggest that there are inherent differences in how society responds to male and female problem drinkers (e.g. Forth-Finegan, 1991). Gomberg (1988) found that both women with and without alcohol problems felt there was a more negative attitude towards female intoxication than towards male intoxication. This negative attitude may be a reason why female problem drinkers are reported to conceal their drinking (Dahlgren, 1979), as this would help to avoid a negative response from their partners and other people around them.

Wilson (1980) talked of the stigma attached to women’s drinking and suggested that this gave rise to feelings of shame and embarrassment in male partners of female problem drinkers. There is some support for this idea as comments about the stigma attached to having a female partner with a drug problem were made by several males in the research carried out by Laudet et al. (1999). The stigma and negative attitude surrounding female problem drinking may mean that those around a female problem drinker will try to hide the drinking from the outside world, but at the same time will be rejecting and scornful towards her (Kagle, 1987). It is suggested that this rejection
is reflected in the higher proportion of female problem drinkers who are separated or divorced, compared with male problem drinkers (Gomberg, 1988).

If male partners feel ashamed of or embarrassed by their female partner's drinking, they may find it hard to tolerate her drinking behaviour and therefore feel unable or unwilling to support her. In a study looking at women's views of using alcohol and other substances, Raine (2001) found that a common reported reaction of male partners was to distance themselves from the female's drinking behaviour, both physically (for example, by going into a different room or going out) and emotionally (for example, by avoiding confrontation or active involvement in the substance use problem). This idea is supported by a study looking at the coping behaviours of family members of people with substance use problems in Mexico and England (Orford et al., 2001). As mentioned previously, analysis of subgroups within this study found that the English husbands of wives with alcohol problems had the highest withdrawal coping scores. Therefore it might be expected that this finding would be replicated and that male partners would report using a high frequency of withdrawal coping behaviours.

The stigma attached to female problem drinking suggests that relatives will do more to try to change the problem drinking behaviour of females than they would of males. Controlling alcohol consumption is one way that family members can try to change drinking behaviours (Yoshioka, Thomas & Ager, 1992). Holmila, Mustonen and Rannik (1990), looking at alcohol use and its control in Finnish and Estonian couples, found however that wives were more likely than husbands to attempt to control their spouse's drinking. They found that half of the wives in their sample reported trying to
control their partner’s drinking but that this was very rarely the case amongst the
husbands, and concluded that there were gender differences in trying to cope by
controlling a spouse’s alcohol consumption. This contrasts with what would be
expected due to the negative societal attitude towards female drinking. Holmila et al.
(1990) commented on the fact that control of alcohol consumption is a part of the
Finnish culture, therefore it could be questioned whether a similar phenomenon would
be seen in other cultures and other countries such as Britain. This study also utilised a
general population sample so its findings may not translate to a sample of drinkers in
contact with treatment agencies. Attempts to control alcohol consumption were also
found to be related to the frequency of drinking, which corresponds with the idea that
people engage in more coping behaviours when they have more to cope with (Orford
et al., 1975). Therefore in a treatment sample where drinking is problematic, it could
be assumed there would be a high frequency of problem drinking behaviours and
therefore a high frequency of controlling behaviours.

The idea that male partners may not try to control their female partner’s substance use
is supported by research carried out in the USA with male partners of women who
were receiving treatment for cocaine use (Laudet et al., 1999). This study focused on
the attitudes of male partners towards the female’s treatment and found that although
male partners had a negative attitude towards the women’s substance use and a
positive attitude towards them seeking treatment, the men’s behavioural support of
that treatment was passive and inconsistent. The study described the behaviours of the
male partners that were seen to support the female’s treatment, and there was no
mention of the male partner actively trying to control his partner’s substance use. This
is one of the only research studies looking at male partners of female substance users, but unfortunately it does not describe any of the males’ experiences of coping.

The finding that in the general population male partners do not try to control their female partner’s drinking and the existence of a strong negative attitude towards female drinking, may both be explained by the stereotypical gender roles that are held in Western societies. Women are traditionally seen as carers; as providing personal services to others and subsuming their own needs (Raine, 2001). Holmila et al. (1990) found more control of husbands’ drinking by wives than vice versa and held the view that it is a normal part of a wife’s role to control her husband’s drinking. This is reflected in a comment made by Bailey, Haberman and Alskne (1962) in a report of a study looking at women married to problem drinkers, which suggested that a wife has a certain responsibility for her husband’s drinking. They wrote that in those cases where the husband had continued to drink heavily:

“Circumstances had perhaps not motivated [the wife] so strongly to “do something” about their husbands’ alcoholism.”

(p. 622)

The fact that a male partner is not seen as trying to control a female’s drinking may reflect how society does not expect him to adopt a caring role. Orford et al. (2001) hypothesised that higher withdrawal scores in male partners would be due to the fact that family duties fall more heavily on women, therefore males would not see it as part of their role to become involved in a partner’s drinking problem. They also hypothesised that this would lead to more tolerant and inactive coping in female
partners as they tried to maintain the family unit. Orford et al. (2000) did find support for this hypothesis in that female partners did report more tolerant and inactive coping behaviours, but this difference was not significant in their English sample.

If a drinking problem means that the traditional caring role of a female is compromised, Raine (2001) suggested that the female problem drinker feels they are failing other family members. Kagle (1987) suggested that those around a female problem drinker are often more concerned with her family duties, such as caring for children and doing housework, than with her own well-being. According to this perspective, when individuals who abuse alcohol are not able to effectively fulfil traditional gender roles, they elicit negative consequences from their environment (Brennan, Moos & Kim, 1993). Zweben (1986) suggested that the level of stress experienced was related to the extent to which problem drinking interfered with everyday life. This suggests that if a female is able to maintain her caring role, then her drinking may not be seen as a problem. It may be easier for women who do not work to maintain an adequate level of functioning, so that those around her do not feel her drinking is causing problems. Raine (2001) found that a change in a woman’s drinking behaviour was only welcomed by the male partner if it did not challenge established patterns of behaviour. Therefore if a female is maintaining her roles and duties, a change in her drinking behaviour may be seen to threaten the stability of the family.

Researchers have found differences in the way that people perceive problem drinking in males and females (Gomberg, 1988; Plant, 1997; Waterson, 1996), and it is suggested that there are also the societal and cultural influences of the traditional
gender roles that affect how partners will try to cope with problem drinking behaviour. It could be argued that this would lead to different responses to problem drinking behaviours from male and female partners, and in particular, that male partners would use fewer engaged and active coping behaviours that tried to control or change the drinking behaviour. It could also be argued that younger couples are less constrained by the traditional stereotypes of male and female roles, and that there is now a more permissive attitude towards female drinking (Plant, 1997). But as stated earlier, there is little research evidence to show that these social and cultural influences on drinking in males and females lead to differences in coping behaviours.

Measuring coping

Although little is known about the coping behaviours of male partners, there is a substantial body of research looking at coping in families. Studies looking at the ways in which families cope with alcohol problems have broadly fallen into two categories: those that have used dispositional measures (e.g. Moos et al., 1982) and those that have used alcohol-specific measures (e.g. Hurcom et al., 1999; Orford et al., 1992; Orford et al., 1998; Rychtarik, Carstensen, Alford, Schlundt, & Scott, 1988).

Dispositional measures

When coping is seen in dispositional terms, it is regarded as a personality characteristic; how someone copes in one situation is seen to reflect how they cope in other situations. Studies that have used a dispositional measure of coping have often asked participants how they coped with a stressful event from their recent past, often one that is not related to their family member's drinking (e.g. Finney, Moos, Cronkite & Gamble, 1983). This method of assessing coping allows for comparisons between
family members who have a relative with an alcohol problem and control groups of relatives of non-problem drinkers. For example, Cronkite et al. (1990) found differences in the coping of spouses of problem and non-problem drinkers. They also found that spouses of drinkers who had remitted and spouses of non-problem drinkers were coping equally well with ongoing stressors. These findings supported the idea that it was the problem drinking that led to stress in the family, and the differences in coping. Studies of this type support the stress perspective and the stress and coping approach, but tell us little about the actual experience of trying to cope when a family member has an alcohol problem.

Studies that have used a general measure of coping have been criticised due to the use of pre-determined coping dimensions that have originated from the theoretical literature (Orford et al., 1998). The use of this methodology also assumes that a person's general coping repertoire determines their alcohol-related coping (McCready, 1990) but Rychtarik (1990) questioned the extent to which this relationship existed. Coping has also been seen as specific to a situation (Beckham & Adams, 1984; Lazarus & Folkman, 1984) therefore other researchers have used measures that focus on coping with alcohol problems per se.

**Situational measures**

In contrast to dispositional measures, situational measures are based on the premise that coping is a direct response to a specific situation. Rychtarik et al. (1988) developed a situation-specific measure to assess alcohol-related coping skills. Family members were asked to imagine themselves in hypothetical situations related to an interaction with their problem-drinking relative and then report what they thought
they would do. The scoring criteria developed for this measure rated coping behaviours according to an assumed positive or negative outcome for the drinker. In these terms, relatives were often seen as lacking in the coping skills that could lead to a positive outcome for the problem drinker and therefore became the target for intervention themselves. Despite questioning family members, the focus of this measure was the possible effect of coping behaviours on the problem drinker.

Whilst completing the situation-specific measure (Rychtarik et al., 1988) it would be possible to respond in a socially desirable way and give answers indicating what you thought you should do, rather than what you would do. Lazarus and Folkman (1984) suggested that the coping process should be assessed by looking at what people actually do, rather than what they usually do, or feel they would or should do. Orford and colleagues have developed a questionnaire (Orford, 1996) which avoids this problem by asking what people have actually done whilst trying to cope with a relative’s substance use problem.

**The Coping Questionnaire**

The development of the Coping Questionnaire (Orford, 1996) was based on a series of studies in which relatives were interviewed and asked about how they coped with a relative’s substance use problem (Orford et al., 1975; 1992; 1998) and did not use predetermined coping dimensions (a criticism of the dispositional coping measures).

Orford et al. (1992) carried out interviews with 50 relatives of drug users and using the qualitative data gathered, derived eight ways of coping. Orford et al. (1998) looked at the coping behaviours of mainly female relatives of drug and alcohol users
in Mexico and England. Analysis of the data from this study did not confirm the eight ways of coping found in their previous research, but revealed three coping factors: engagement (where the relative attempts to change the drinker's behaviour); tolerant and inactive (where the relative accepts or is inactive in relation to the problem); and withdrawal (where the relative reduces their interactions with the drinker).

Following on from the research by Orford et al. (1998) which found that coping was best described by the three factors of engagement, tolerance and withdrawal, Hurcom et al. (1999) looked at the predictors of these different types of coping in a sample of concerned female partners. They found that engaged coping was best predicted by the female's perception of self-demands (the female's beliefs about whether she should use particular coping strategies); that tolerant coping was related to the partner's ability to remove themselves from the drinker and the degree of drink-related hardship experiences by the family; and that withdrawal coping was predicted by how long the drinking problem had been going on and beliefs about the necessity of withdrawal from the drinker.

**Coping Theories**

Dispositional and situational measures of coping reflect the two underlying theories of coping: coping as a fixed trait; and coping as a dynamic process (Lazarus, 1993).

**Trait Theory**

Where coping is considered as a trait, it is seen as a fixed personality characteristic and this idea has its origins in psychodynamic theories (Lazarus & Folkman, 1984). The idea that a person may have a characteristic way of coping has been undermined
by research findings. Folkman and Lazarus (1980) found that nearly all their community sample used more than one type of coping in the majority of the stressful events they looked at. The trait view of coping is also challenged by the finding that coping styles are not static and that people report using different types of coping at different times (e.g. Velleman et al., 1993). These theoretical challenges led to the development of the process view of coping.

**Process theory**

When considered as a process, coping has been defined as:

"...ongoing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person."  

*(Lazarus, 1993, p. 237)*

Figure 1 shows a representation of the process model of stress and coping (Lazarus & Folkman, 1984) and is seen as providing a framework for thinking about the process of coping when a relative has an alcohol problem. The model suggests that a coping behaviour occurs after a series of cognitive appraisals. Initially a situation or event has to be appraised as stressful; as presenting a threat, challenge or having caused harm or loss (Lazarus & Folkman). An event or situation is seen as irrelevant if it has no impact on a person and benign-positive where it is positive and therefore enhances, or benign and therefore preserves a person’s well-being (Lazarus & Folkman). Where an event is appraised as irrelevant or benign-positive, a person is seen as not needing to engage in any form of coping. If however the event is appraised as stressful, a second level of appraisal takes place which helps to determine which type of coping a person
will use. This process model of stress and coping has been supported by research findings (e.g. Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986).

Figure 1 – A representation of Lazarus and Folkman’s (1984) process model of stress and coping (adapted from Beresford, 1994).
Implications of the model for coping with problem drinking

In terms of family members trying to cope when a relative has an alcohol problem, the process model of stress and coping suggests that the problem drinking would be the potential stressor (see Figure 1). The drinking behaviour has to be appraised as stressful and problematic before coping is seen as necessary and before the second level of appraisal determines the type of coping behaviour that the relative would use.

The primary appraisal

The primary appraisal that takes place in the process model of stress and coping determines whether an event or situation is seen as producing threat, harm or a challenge. When male partners experience a female partner’s drinking behaviours, this process suggests that the drinking behaviour initially needs to be appraised as problematic before coping behaviours are used. There are conflicting factors that suggest male partners may be more or less likely to see the drinking behaviour as problematic.

Where the stressor is problem drinking behaviour, not only can it be seen as problematic for the relative, but it also has an impact on the problem drinker. In a study looking at the dynamics of a stressful event, Folkman et al. (1986) found that where an encounter involved concern for a loved one’s well-being, people used more confrontational coping and less coping behaviours that distanced them from their loved one. The authors suggested that people found it difficult to be emotionally and behaviourally detached when the interests of someone close to them were at stake. Confrontational coping falls within the engaged coping factor presented by Orford et al. (1998) and distancing behaviours are seen as part of the withdrawal subscale of the
Coping Questionnaire (Orford, 1996). Therefore, despite their being some evidence that male partners report more withdrawal behaviours (Orford et al., 2001) if they are concerned about a female partner’s well-being, they may show more engaged coping behaviours and less withdrawal coping behaviours.

Higher levels of engaged coping may be more pertinent to other relatives than partners. Orford et al. (1992) found that partners of drug users used significantly more angry and withdrawing coping behaviours than did parents of drug users. This may be due to the different roles of partners and parents, and suggests that parents may find it harder to detach themselves from the user. There are questions over whether a similar pattern would be seen in partners of problem drinkers, but Velleman et al. (1993) commenting on the same piece of research, suggested that the results found with drugs users were comparable to those for drinkers and that the main difference was the higher incidence of stealing and lethargy seen in the drug users. Although Orford et al. (1992) included a small number of male family members, no gender differences were reported.

**Gender differences in drinking behaviour**

Gender differences in drinking behaviours have been reported (Plant, 1997) and different patterns of drinking have different effects on the functioning of a family (Collins, 1990). Therefore characteristics of the female’s drinking behaviour may affect whether her drinking is seen as problematic by a male partner.

In a study looking at wives of male problem drinkers, Dunn, Jacob, Hummon, and Seilhammer (1987) found that where drinking took place at home, the drinking
behaviour was seen as more predictable and the experience of stress was less than when drinking took place out of the home. They suggested that where drinking took place at home, the family had adapted to the drinking and it had been incorporated into family life. Amongst those who drank out of the home, the drinking pattern was variable and chaotic and the drinker’s behaviours created greater experiences of stress for the family. Therefore if female problem drinkers drink at home, it would be expected that their behaviours might cause less stress in the family. The Dunn et al. (1987) study consisted of only male drinkers and was based on information from only eight couples, therefore it may be that this finding would not be replicated with a larger sample or a sample of female problem drinkers.

If it is taken that the behaviour of at-home drinkers is more predictable and produces less stress for families, the finding that more females tend to drink at home (e.g. Corrigan & Butler, 1991) suggests that in general they will cause less disruption to their families than male problem drinkers. Therefore male partners may not feel that the female problem drinker’s behaviour is as problematic. Finney et al. (1983) suggested that the level to which problem drinking interferes with everyday functioning of the family may determine the level of stress in the relationship between the drinker and the partner. Here the suggestion is that if the female problem drinker can maintain her role then less stress will be experienced. This may exaggerate the idea that the male partner does not see his partner’s drinking as problematic, and in such a case a male partner may be more tolerant of the drinking behaviour. There is also some evidence that female problem drinkers are more able than male problem drinkers to conceal their problem-drinking from those around them (Dahlgren, 1979) and this could add to male partners not seeing the drinking as a problem.
In the study carried out by Laudet et al. (1999) some of the male partners felt that their female partner did not need treatment or that it was not their responsibility to support her. If a substance use problem is not seen as requiring treatment, it can be assumed it is not seen as a problem and therefore coping is not seen as necessary. In a study looking at the help-seeking behaviour of male and female problem drinkers, Thom (1986) found that when a woman perceived her drinking as non-problematic, this idea was supported by her spouse. Several of the women she interviewed reported that their spouse was unsupportive of treatment, either preventing or discouraging her from seeking help or by encouraging her to drink even when she had herself begun to worry about her alcohol consumption. Only one out of the 25 women she interviewed reported that her husband saw alcohol as her main problem. In contrast Thom found that all 25 of the male problem drinkers said that their wives had made such remarks.

Beyond the finding that female drinkers may cause less stress if they drink at home and that male partners may not be supportive of a female’s treatment, there are other factors which suggest that male partners may not see the female’s drinking as problematic. One of these is the male’s own alcohol consumption.

**Male partners’ own drinking**

A male’s attitude to the drinking of his female partner may be mediated by his attitude to alcohol in general and may therefore be reflected in his own alcohol consumption. Many studies of female problem drinkers report that a high number have a heavy drinking partner (Bromet & Moos, 1976; Dahlgren, 1979; Dahlgren & Myrhed, 1977; Thom, 1986), and that many of these male partners have drinking problems themselves (Rimmer, 1974; Mulford, 1977). For example, Dahlgren and Myrhed
(1977) found that half of the married or cohabiting problem drinking women in their sample had spouses whom they classed as alcoholic, compared with only 13% of spouses of the male problem drinkers. Therefore a high number of heavy drinkers would be expected in a sample of male partners of female problem drinkers.

One idea as to why many female problem drinkers have heavy drinking spouses is assumptive mating; the idea that a heavy drinker is more likely to marry another heavy drinker rather than a teetotaller (Dahlgren, 1979). Holmila (1994) suggested however, that as in general men drink more than women, having a heavy drinking spouse or partner is more likely for a woman. Dahlgren (1979) found that amongst the 20 female problem drinkers in his study who reported few marital problems, 16 were married to men who themselves had a drinking problem. These male partners may have been unaware of their wives drinking problems due to their own heavy drinking, or their own drinking may have led to a greater tolerance of the wives’ drinking.

Raine (2001) saw the social context in which drinking took place as providing a set of beliefs about the drinking which could act as a barrier to the definition of a drinking problem. Therefore if a female problem drinker has a heavy drinking partner, drinking together may provide some sense that the drinking is not problematic. Hammer and Vaglum (1989) cited a general population study carried out by Holmila (1987), in which half the women reported drinking in the company of their spouse, as opposed to only a third of the men. Corrigan and Butler (1991), in a study of Irish female problem drinkers entering treatment, found that 92% of the women reported that they drank with their partners. Therefore combined with the fact that a high number of female problem drinkers have been found to have heavy drinking partners, there may
be little to lead the male partner to think that the female’s drinking is problematic. If males and females are drinking together and drinking equal amounts, there is evidence that this would have a greater physical, emotional and social impact on the female and cause her more problems (Bonger, Van de Goor, Van Oers & Garretsen, 1998; Corrigan, 1974; Department of Health, 1995).

Associations between a couple’s alcohol intakes have also been reported. In a Scandinavian general population survey, Hammer and Vaglum (1989) found a relationship between a husband’s alcohol consumption and his wife’s, and a high degree of association between a woman’s drinking and that of her partner was found in an American population study where moderate to heavy drinkers were identified and interviewed (Wilsnack, Wilsnack & Klassen, 1984). In this study, moderate drinkers were seen as those who had four or more drinks per week, which in terms of a treatment population is a low level of alcohol consumption. Treatment services often use the current government guidelines as a measure of what is a high or risky level of alcohol consumption. These guidelines are based on the Sensible Drinking report (Department of Health, 1995) which stated that men should not exceed four units of alcohol a day. Therefore more than four units a day, or 28 units a week is seen as a high level of alcohol consumption.

In looking at factors associated with a positive outcome from treatment, Beattie et al. (1993) found that those drinkers who had people around them who supported their problem drinking had a worse treatment outcome than those with no support. The authors measured alcohol-relevant support in a drinker’s social network by looking at the number of heavy drinkers and abstainers in the network, the encouragement for
drinking and the degree to which the drinker drank alone or with others. The idea that people around a problem drinker can encourage abstinence or maintain drinking behaviours is acknowledged in those approaches that seek to engage a person’s social network in the treatment change process (Copello et al., 2002; Galanter, 1993).

If a female has a male partner who himself drinks heavily, there will be support for heavy drinking in her environment. Bromet and Moos (1976) have suggested that the salience of alcohol in the environment may encourage drinking among individuals who in other circumstances may not have become heavy drinkers. Therefore it could be suggested that where a woman has a heavy drinking male partner, the shared environment of the couple would not be conducive to her attempts to cut down her own alcohol consumption.

Therefore it is suggested that a male’s own alcohol consumption will affect how he perceives the female’s drinking and may mean that a heavy drinking male partner will show more tolerance than a male partner who has a low alcohol consumption. A heavy drinking male partner may also be less likely to see the female’s drinking as problematic. If he does not see the female’s drinking behaviour as problematic, the male partner will not need to cope (see Figure 1) and would be expected to report a low frequency of coping behaviours. Where the male partner does see the female’s drinking as problematic, the process model of stress and coping suggests that a second level of appraisal takes place that determines what type of coping behaviour is used.
Secondary appraisal

In a study looking at the dynamics of a stressful event, Folkman et al. (1986) found that those situations that were seen as amenable to change led to different coping behaviours when compared with those that were seen as unchangeable. Folkman and Lazarus (1980) saw coping behaviours as falling into two types: problem-focused and emotion-focused. They saw the function of problem-focused coping as the management or alteration of the person’s relationship with the environment through changing something about the environment or oneself, and the function of emotion-focused coping was seen as the regulation of stressful emotions through changing what is attended to (e.g. vigilance or avoidance) or through changing the relational meaning of what is happening. Where it was seen that a situation could be changed, Folkman et al. (1986) found that there was a tendency to use problem-focused coping strategies and where it was seen that a situation could not be changed, emotion-focused coping strategies were used. The authors suggested that where it was thought nothing could be done to change a situation, then problem-focused coping would be counter-productive and emotion-focused coping would be more effective at lowering the arousal associated with the stressor.

Bennett and Wolin (1990) stated that families look for reasons to explain behaviours and whether a male thinks his female partner’s drinking behaviour will change, will depend on his beliefs about the drinking. The disease model of drinking summarises a common set of beliefs about drinking behaviours which are advocated by Alcoholics Anonymous (Davies, 1997; Tournier, 1979). The disease model of drinking sees the cause of the drinking behaviour as something that is inside the drinker, something that will not change and something that cannot be controlled by the drinker (Davies,
1997). If a male partner holds this view of drinking then he will not believe that his partner is to blame for her drinking and may be more tolerant of her drinking behaviour.

This set of beliefs form a set of attributions as to the cause of the drinking. The attributions that people make are seen to predict their subsequent emotional reactions and behavioural responses (Munton, Silvester, Stratton & Hanks, 1999). Therefore attributions are seen to have a role in the process model of stress and coping (see Figure 1) and contribute to the secondary appraisal process (Lazarus & Folkman, 1984).

There are seen to be several different attributional dimensions. The most widely reported of these are the internal/external dimension, the stable/unstable dimension, and the controllable/uncontrollable dimension (Farr & Anderson, 1983; Munton et al., 1999). When thinking about the internal/external dimension, a common finding relates to the actor–observer difference (Davies, 1997; Farr & Anderson, 1983; Munton et al., 1999). This reflects the difference that is seen when someone explains their own behaviour and that of someone else. When someone explains the cause of their own behaviour, they are more likely to make an attribution that it is external to themselves (situational), whereas if they explain the behaviour of others, they are more likely to make an attribution that the cause is internal to that person (a dispositional attribution) (Davies, 1997; Farr & Anderson, 1983; Munton et al., 1999). This actor-observer difference was reported in a study looking at the attributed causes of relapses in problem drinking. McKay, O’Farrell, Maisto, Connors & Funder (1989) found that wives of male problem drinkers made more dispositional attributions than
their husbands. Therefore, when asking males to explain the drinking behaviour of their female partner, it is expected that they would make more internal attributions as to the cause of her drinking behaviour (i.e. they will believe that the cause of her drinking lies within her).

Whether the drinking behaviour is seen amenable to change is a function of whether it is seen as stable and controllable (Munton et al., 1999). If a male partner believes that the drinking behaviour can change, then he is likely to make attributions that the cause of the drinking is unstable and controllable. If he believes that the drinking behaviour cannot change then he is likely to attribute it to a cause that is seen as stable and uncontrollable. The latter of these attributional patterns is seen as consistent with the disease model of drinking.

If the cause of the drinking problem is seen as unstable and controllable (that it can change), it is suggested that male partners are more likely to engage in active coping strategies and if they see the cause of the drinking as stable and uncontrollable (that it cannot change), then they will be more likely to use distancing and avoidant behaviours (Folkman et al., 1986). Problem-focused coping is active and aims to change the situation, so is seen to be consonant with the engaged coping presented by Orford et al. (1998). Emotion-focused coping is seen as changing the way the situation is attended to and includes distancing and avoidant behaviours, so would include those behaviours that are part of the withdrawal subscale (Orford et al., 1998).

Causal attributions are therefore seen as part of the secondary appraisal process (Lazarus & Folkman, 1984) which leads to a decision over which coping behaviours
will be used. It is suggested that where male partners see the cause of their female partner's drinking as changeable, they will use more engaged coping, and where it is seen as unchangeable, that they will use more withdrawal coping behaviours. Where drinking behaviour is seen as unchangeable, this set of beliefs corresponds with the disease view of drinking. This suggests that male partners who see drinking as unchangeable will report more tolerant coping behaviours as they do not believe their female partner is to blame for her drinking behaviour.

**Measuring attributions**

Rotter (1966) developed a widely used scale that looks at the locus of causality (i.e. whether the cause is seen as internal or external to a person), but researchers have suggested that other attributional dimensions need also to be considered (Russell, 1982). Peterson et al. (1982) developed a general measure of attributions based on the learned helplessness model which looked at attributions in terms of whether their locus was internal or external, and whether they were stable or unstable and global or specific. Drinking behaviour was seen as a specific behaviour, therefore this measure was not seen as appropriate for measuring the attributions relating to drinking behaviour.

A specific alcohol-related measure was presented by Donovan and O'Leary (1978) but this only looked at the locus of causality dimension presented by Rotter (1966). The Causal Dimensions Scale (Russell, 1982) looked at the causes for events in terms of the locus of causality, stability and controllability and has been adapted and used to look at the causes of a range of behaviours (Grove, 1993; Kellett, 2002; Scaufeli,
1988). This is seen to measure the attributional dimensions that are relevant to drinking behaviour and to the secondary appraisal process.

**Process of reappraisal**

Whether a male partner believes that his partner's drinking behaviour can change may also be a function of how long the drinking has been problematic. The process model of stress and coping (Figure 1) shows that the continuing coping efforts of a relative are seen to be affected by previous attempts to cope, the outcome of which are evaluated and taken into account in future appraisals about the drinking behaviour. The process model of coping would suggest that where a coping behaviour leads to further drinking, the reappraisal process would tell a family member that they should change their coping behaviour, as the behaviour had been unsuccessful in stopping the problem drinking. This idea gained some support from the finding that family members who try to cope when a relative has a substance use problem will switch between different coping behaviours in an attempt to find something that will help to resolve the problem (Velleman et al., 1993). But in looking at the outcome from coping behaviours, researchers have focused on what is positive and negative for the problem drinker. For example, Gorman and Rooney (1979) saw 'negative' coping behaviours as those that reinforced the problem drinking behaviour as they did little to help the problem drinker. In this study there was no measure of whether the coping behaviours led to a positive or negative outcome for the family member.

In terms of what is best for the problem drinker and what promotes abstinence, family members have been found to need to cope in a way that does not reinforce drinking, for example, by not rewarding drinking behaviour through pacifying or protecting the
drinker (McCraday et al., 1986). Barber and Crisp (1995) suggested that partners and family members are in a difficult position, in that they must also avoid punishing or controlling the drinker as this may encourage and cue further drinking behaviours. These ideas suggest that the coping behaviours of family members can have a role in maintaining problem drinking (Collins, 1990). Orford (1992) suggested that family members find it hard to make a distinction between supportive and tolerant coping behaviours; supportive behaviours have the potential to help someone overcome the drinking problems but tolerant behaviours can take away the consequences of a person’s actions and thereby reinforce the drinking.

Folkman et al. (1986) suggested that even when there was not a resolution of the problem causing the stress, an outcome could be evaluated favourably if the person doing the coping felt that the situation had been managed as well as could be expected. Therefore the family member may not evaluate the outcome of a coping behaviour in terms of the prognosis for the problem drinker, suggesting that they may evaluate the outcome of a coping behaviour by its short term rather than long term effect. In two families observed by Wilson (1980) where the wife was a problem drinker, the female would drink in a room on her own and the family would keep their distance. Both the women said they drank because they felt unable to cope with family pressures and that the drinking gave them some reprieve. In these examples, the families' avoidance led to a positive short-term effect in that there was presumably less conflict in the family, but can also be seen as having a negative long-term effect due to reinforcing the drinking. Therefore families may do things that do not help to resolve the drinking problem in the long term, but that provide an immediate positive effect.
As mentioned previously, one of the only reported findings regarding the coping of male partners found that they reported a high frequency of withdrawal coping behaviours (Orford et al., 2001). Orford et al. (1998) suggested that the avoidant and independent behaviours that characterise the withdrawal factor of their coping questionnaire, may be more functional for the family member than for the problem drinker. The withdrawal behaviours can be seen as creating a distance between the family member and the problem drinker and gives the family member a reprieve from the drinking behaviour which can be seen as a short-term positive outcome. In the long-term, withdrawal behaviours may lead to a reinforcement of the problem drinking, for example, if the drinker drinks to avoid conflict with a family member.

Therefore family members may be seen to engage in coping behaviours that are self-defeating as they do not help to resolve the problem drinking, but it is suggested that these behaviours may provide short-term benefits for the family.

**Coping changing over time**

The process model of stress and coping (see Figure 1) suggests that the outcome of a coping behaviour is evaluated and that this affects future coping attempts. Coping is seen as changing over time, on the grounds that what a person attends to in their environment changes over time too (Lazarus, 1993). How family members cope when a relative has an alcohol problem has also been found to be changeable over time (James & Goldman, 1971).

Where a stressor is not resolved and continues to be presented, Lazarus and Folkman (1984) talked of a prolonged stress. They suggested that prolonged exposure to a
stressor leads to a lessening of the arousal associated with it. They questioned whether this was to do with the process of habituation or to being worn down by the stressor. This process seems to apply to how people cope when a relative has an alcohol problem. In a study of wives of problem drinkers, Rychtarik (1990) asked them to say what they would have done in a series of alcohol-related hypothetical situations. He found that the longer the drinking had been a problem, the more desensitised or emotionally isolated the wife was and the more passive her responses were. This seems to reflect the idea that the longer people have tried to cope with a stressor, the more used to it, and the less aroused by it they will be. This suggests that where a drinking problem has a long history, relatives may show more tolerance.

From information gathered from qualitative interviews with 50 relatives of drug users, Orford et al. (1992) found that in the case of partners of drug users, there was a trend towards them using more non-confrontational coping as the length of exposure to the drug use increased. Those partners who had experienced the problem for more than eight years had the most kind and non-confrontational interactions with the user and in those cases where the problem had been evident for 2 years or less, the partners showed the least. Non-confrontational coping is seen as part of the tolerant and inactive coping subscale of the Coping Questionnaire (Orford et al., 1992) and this finding supports that of Rychtarik (1990) that where a drinking problem has been long-standing, wives reported more passive coping behaviours. Therefore there is some evidence that a prolonged exposure to the stress created by problem drinking behaviours leads to a process of habituation. Orford et al. (1992) questioned whether this effect was due to those who were least likely to be tolerant, withdrawing and
disengaging from the user early on in the course of the problem, or due to an artefact of the length of the drinking problem.

Lazarus and Folkman (1984) also suggested that when exposed to prolonged stress, a person could either modify their coping behaviours so that they could try to resolve the problem, or they could avoid and distance themselves from the stressor. Hurcom et al. (1999) found a positive correlation between the withdrawal coping scores of the Coping Questionnaire and how long the drinking had been problematic. This supported the suggestion of Lazarus and Folkman that in dealing with a prolonged stress, people can avoid and distance themselves from it. Orford et al. (1998) reported a high level of withdrawal behaviours in their sub-sample of husbands of female problem drinkers, but it is unclear if the length of the drinking problem played a role in this phenomenon.

These findings suggest that higher tolerant and withdrawal coping scores on the Coping Questionnaire would be seen where the drinking problem had been problematic for longer.

**Multiple coping behaviours**

The concept of appraisal is seen as a key part of the process model of stress and coping (as shown in Figure 1) as it is acknowledged that although a group of people may find themselves in similar situations, they are unlikely to all respond in the same way (Lazarus & Folkman, 1984). Therefore one would not expect all male partners of female problem drinkers to exhibit the same coping behaviours.
As well as expecting a range of coping behaviours to be reported, it is expected that individuals will report using more than one type of coping. Folkman and Lazarus (1980) found that nearly all their sample used both problem-focused coping (coping that aims to change some aspect of the situation) and emotion-focused coping (coping that aims to change the way the situation is attended to or thought about) in stressful encounters. This was supported by Orford et al. (1992) who found that relatives described using a range of coping behaviours and that some of their behaviours combined several different ways of coping. The idea that people use different ways of coping was also found by Velleman et al. (1993) who found that relatives did not usually choose one particular method of coping and stick to it, but that they swung from one coping position to another in an attempt to find something that might resolve the substance use problem.

Summary

Although there is a considerable amount of research looking at how family members cope when they have a relative who has a substance use problem, there has been no research looking specifically at the coping behaviours of male partners of female drinkers. This is despite gender differences and coping being recognised as an important area of research (Orford et al., 1998).

In a study looking at how family members cope, Orford et al. (2001) found that husbands of female problem drinkers reported the highest frequency of using withdrawal coping behaviours of all family members in their sample. Beyond this, few gender differences in the literature on families and alcohol problems have been reported. Gender differences have been reported in the general literature, but it
remains to be seen whether these translate to male partners of female problem drinkers.

There are strong societal and cultural attitudes towards alcohol use as well as traditional gender roles and it is suggested that these will play a part in determining the coping behaviours that male partners use.

The process model of stress and coping (Lazarus & Folkman, 1984, as shown in Figure 1) is seen as providing a framework for thinking about how male partners cope when they have a female partner who is a problem drinker, and several factors are seen as influencing this model. Among these are the male partner’s own alcohol consumption, the length of time the drinking has been problematic and the attributions the male partner makes about the cause of his female partner’s drinking behaviour.

**Aims of the current study**

The three aims of the current study were:

- to explore the coping behaviours of male partners of female problem drinkers using the Coping Questionnaire (Orford, 1996).

- to compare the Coping Questionnaire scores of male partners with those of a comparison sample of female partners of male problem drinkers.

- to investigate the effect on the male partners’ coping behaviours of his attributions as to the cause of the female’s problem drinking, his own alcohol
consumption, the extent to which he saw the drinking as problematic and the duration of the drinking problem.

Hypotheses

The above literature review led to the following hypotheses about the coping behaviours of male partners of female problem drinkers:

1. Coping behaviours of the male partners

   Hypothesis 1: Male partners of female problem drinkers would report using more than one type of coping behaviour.

2. Gender differences in coping behaviours

   Hypothesis 2: There would be differences between the reported coping behaviours of the male partners of female problem drinkers in the current study and the female partners of male problem drinkers in a comparison sample.

   Hypothesis 2.1: Male partners in the current study would report a lower frequency use of engaged coping behaviours when compared to female partners in a comparison sample.
Hypothesis 2.2: Male partners in the current study would report using a higher frequency of withdrawal coping behaviours when compared to female partners in a comparison sample.

3. Attributions about the drinking

Hypothesis 3.1: Male partners would make a high number of internal attributions as to the cause of the female’s problem drinking.

Hypothesis 3.2: Where male partners made attributions indicating that they saw the cause of the problem drinking as unchangeable, they would report a higher frequency of withdrawal coping behaviours than those male partners who saw the cause as changeable.

Hypothesis 3.3: Where male partners made attributions indicating that they saw the cause of the problem drinking as unchangeable, they would report a higher frequency of tolerant coping behaviours than those male partners who saw the cause as changeable.

Hypothesis 3.4: Where male partners made attributions indicating that they saw the cause of their female partner’s drinking as changeable, they would report using more engaged coping behaviours than those male partners who saw the cause as unchangeable.
4. Role of male’s own alcohol consumption

*Hypothesis 4.1:* There would be a high number of heavy drinking male partners in the sample in the current study.

*Hypothesis 4.2:* Where male partners were classed as heavy drinkers they would report a higher frequency of tolerant coping behaviours than those with a lower alcohol consumption.

*Hypothesis 4.3:* Male partners who were classed as heavy drinkers would gain lower Coping Questionnaire scores than those with a lower alcohol consumption.

5. Perception of the female’s problem drinking

*Hypothesis 5.1:* Where male partners did not see their female partner’s drinking as problematic, they would report a lower frequency use of all coping behaviours than those who saw drinking as problematic.

*Hypothesis 5.2:* Male partners who were classed as heavy drinkers would not see their partner’s drinking as so much of a problem when compared with those with a lower alcohol consumption.
6. Length of drinking problem

Hypothesis 6.1: Where male partners reported that the duration of the female's drinking problem was longer, they would report using more tolerant and inactive coping behaviours.

Hypothesis 6.2: Where male partners reported that the duration of the female's drinking problem was longer, they would report using more withdrawal coping behaviours.

Although the current study did not aim to prove the existence of these interactions, Figure 2 shows how the variables in the above hypotheses are seen to fit into the process model of stress and coping (Lazarus & Folkman, 1984).
Figure 2 – The process model of stress and coping (adapted from Beresford, 1994) showing the hypothesised influences of the independent variables in the current study.
CHAPTER TWO - METHODOLOGY

Design
The aim of the current study was to explore the coping behaviours of male partners of female problem drinkers and to consider factors that were likely to affect their choice of coping behaviour. To achieve this, the study employed an independent sample design, with participants recruited by convenience sampling. The study was cross-sectional and a postal questionnaire design with self-administered measures was used to collect the data.

Participants
The participants of the present study were male partners of females who had been referred to a specialist alcohol service for problems with alcohol consumption.

Those male partners who were in contact with services due to their own drinking problems were excluded as it was felt that their own problems could confound those of their partner. Female partners of female problem drinkers were also excluded due to the expectation that this potential group would not be large enough to perform any meaningful comparisons. It was also felt that due to the cultural stereotypes surrounding this group it should be studied separately.

Participants were recruited through two NHS specialist substance misuse services (referred to as Service A and Service B) and through one non-statutory alcohol service (referred to as Service C). Due to the fact that the author was an NHS employee, data
on the numbers of females in the potential sample, the numbers excluded and the numbers approached was only available from the NHS services.

During the data collection period a total of 278 female clients were identified on the caseloads of clinicians in Services A and B. A large number of these were excluded and Table 1 shows the reasons for and numbers of these exclusions. The majority of the exclusions were due to the female not having a male partner (41.7% of the 278 females did not have a male partner) and this included women who were divorced, separated or widowed and those who were not considered by the clinician as being in a steady relationship. The next most common reason for exclusion from the study was due to the female not attending appointments (17.3%) and subsequently being discharged from the service. Amongst the other reasons for exclusion were the clinician feeling that it would not be appropriate to approach a female about the study due to marital/relationship problems, having a female partner, where the male partner was known to be in contact with an alcohol service for his own drinking problems, or due to serious mental or physical health problems in the female or her male partner. In total 209 (75.2%) of the identified females were excluded, leaving 69 (24.8%) who were approached to participate in the current study.

Of the 69 females who were approached about the current study, 23 (33.3%) did not wish to participate and did not give their consent, leaving 46 (66.6%) who did give their consent to participate. In all cases where the female gave consent to participate, the females approached their partner about the study and gained verbal consent for information to be sent to him about the study.
Table 1 – Reasons that females were excluded from the study and the numbers that were excluded due to each reason.

<table>
<thead>
<tr>
<th>Reason for exclusion</th>
<th>Number excluded</th>
<th>(% of all females identified)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No partner</td>
<td>116 (41.7)</td>
<td></td>
</tr>
<tr>
<td>Did not attend appointments</td>
<td>48 (17.3)</td>
<td></td>
</tr>
<tr>
<td>Relationship problems</td>
<td>28 (10.1)</td>
<td></td>
</tr>
<tr>
<td>Male partner in contact with service</td>
<td>6 (2.2)</td>
<td></td>
</tr>
<tr>
<td>Female had serious mental or physical health problem</td>
<td>4 (1.4)</td>
<td></td>
</tr>
<tr>
<td>Male partner had serious mental or physical health problem</td>
<td>4 (1.4)</td>
<td></td>
</tr>
<tr>
<td>Had female partner</td>
<td>3 (1.1)</td>
<td></td>
</tr>
<tr>
<td><strong>Total number of females excluded</strong></td>
<td><strong>209 (75.2)</strong></td>
<td></td>
</tr>
</tbody>
</table>

Total number of female problem drinkers identified 278

Questionnaires were sent to 44 male partners. For the other two male partners where consent had been given, the questionnaires were completed in the presence of the principal investigator during pre-arranged home visits with clinicians.

Sixteen completed questionnaires were returned within two weeks (34.8% of the 46 questionnaires sent or given to male partners). A further two (4.3%) questionnaires were returned blank indicating that the male partner did not wish to participate, leaving 26 male partners who had not responded within two weeks. Reminder letters were sent to 25 of these (in one case marital difficulties became apparent and it was not felt appropriate to send a reminder letter). A further 8 completed questionnaires
were returned. Of those females who were approached about the study through the NHS substance use services, the 26 returned questionnaires represented a response rate of 37.7%.

Two questionnaires were returned from male partners who had a female problem drinking partner who were recruited through the non-statutory alcohol service (Service C), giving a total sample of 28 male partners.

**Demographic information**

Completed questionnaires were returned from a total of 28 male partners. Age data was collected by age band rather than exact age and Table 2 gives the age ranges of the sample. The majority (n=14 (50.0%)) of the male partners were aged between 45 and 54 years.

**Table 2 – Numbers and percentages of male partners and female problem drinkers in each of the age ranges.**

<table>
<thead>
<tr>
<th>Age ranges in years</th>
<th>Numbers (%) of male partners</th>
<th>Numbers (%) of female drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - 34</td>
<td>1 (3.6)</td>
<td>2 (7.1)</td>
</tr>
<tr>
<td>35 - 44</td>
<td>4 (14.3)</td>
<td>5 (17.9)</td>
</tr>
<tr>
<td>45 - 54</td>
<td>14 (50.0)</td>
<td>19 (67.9)</td>
</tr>
<tr>
<td>55 - 64</td>
<td>9 (32.1)</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td>66 +</td>
<td>0</td>
<td>1 (3.6)</td>
</tr>
</tbody>
</table>
Most of the male partners were in full-time employment, (n=21 (75.0%)). One (3.6%) was employed part-time, two (7.1%) were unemployed, two (7.1%) were full-time carers and two (7.1%) were retired.

The numbers of female problem drinkers falling into each of the age ranges are also shown in Table 1. The ages of the female drinkers showed a similar spread. Again the majority of the female problem drinkers were aged between 45 and 54 (n=19 (67.9%)).

Amongst the female problem drinkers, only one (3.6%) was in full-time employment and eleven (39.3%) were in part-time employment. Ten (35.7%) were unemployed, five (17.9%) were full-time carers and one (3.6%) was retired.

Representativeness of current sample

Demographic data from one of the NHS substance misuse services (Service A) was examined to see if the female problem drinkers in the current study were representative of all those who had been referred in the year between April 2002 and March 2003 in terms of age, relationship status and employment status.

Age

Table 3 shows the percentages of the female problem drinkers in the current sample compared to all the female drinkers seen in Service A in 2002/2003. As can be seen, the ages of the females in this sample are concentrated in the 45 to 54 years age range and show less variance than the total referral sample from Service A.
**Relationship status**

Of the females on the clinicians’ caseloads during the data collection period, 48.3% were in a relationship with a male (this excludes some females where information was not recorded due to them not attending assessment appointments). This compares with 49.0% of the total females referred to service A in the 12 month period beginning April 2002.

**Table 3 – Percentages of female problem drinkers in each age range for those in the current study and for all those referred to Service A between April 2002 and March 2003.**

<table>
<thead>
<tr>
<th>Age ranges in years</th>
<th>Percentages of female drinkers in the current study (N=28)</th>
<th>Percentages of all female drinkers seen in Service A 2002-2003 (N=162)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - 34</td>
<td>7.1</td>
<td>18.5</td>
</tr>
<tr>
<td>35 - 44</td>
<td>17.9</td>
<td>35.8</td>
</tr>
<tr>
<td>45 - 54</td>
<td>67.9</td>
<td>29.6</td>
</tr>
<tr>
<td>55 - 64</td>
<td>3.6</td>
<td>12.3</td>
</tr>
<tr>
<td>66 +</td>
<td>3.6</td>
<td>1.2</td>
</tr>
</tbody>
</table>

**Employment status**

Further comparisons were made on employment status between the total female referrals from Service A and the sample from the current study. Similar proportions of females in the two samples were unemployed, house-workers or full-time carers and were retired (see Table 4). The difference between the two samples in the percentages
of those classed as in employment seems to be explained by the fact that the NHS service distinguished between those who were actively working and those who were currently on sick leave.

In summary, in terms of relationship and employment status, the female problem drinkers in this study were representative of all those referred to Service A between April 2002 and March 2003. The ages of the females in the current study were concentrated in the 45 to 54 year age range and tended to be older than those referred to the NHS service.

**Table 4 – Percentages of female problem drinkers in each employment group for those in the current study and those referred to Service A between April 2002 and March 2003.**

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Percentages of female drinkers in the current study (N=28)</th>
<th>Percentages of total female drinkers seen in Service A 2002-2003 (N=155) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed/self-employed</td>
<td>42.9</td>
<td>29.7</td>
</tr>
<tr>
<td>Unemployed</td>
<td>35.7</td>
<td>33.5</td>
</tr>
<tr>
<td>House-worker/full-time carer</td>
<td>17.9</td>
<td>16.8</td>
</tr>
<tr>
<td>Retired</td>
<td>3.6</td>
<td>5.2</td>
</tr>
</tbody>
</table>

* 14.2% of the females referred to Service A were categorised as being on sick leave from work – this category was not used in the current study
Measures

The male partners completed a questionnaire pack that included the Coping Questionnaire (Orford, 1996, Appendix A), the Causal Dimensions Scale (Russell, 1982, Appendix B) and questions designed specifically for this study (Appendix C).


The Coping Questionnaire was developed from qualitative information gathered from interviews with relatives of people with substance misuse problems (Orford et al., 1975; Orford et al., 1998).

The first version was based on interviews with wives of problem drinkers but the questionnaire has been adapted several times so that it is relevant to all family members and to other substance use as well as alcohol use (Orford et al., 1998).

The longer version has 68 questions and a factor analysis of the data collected in one study using the Coping Questionnaire data revealed three coping factors (Orford et al., 1998). These were labelled ‘engaged’, ‘tolerant’ and ‘withdrawal’ coping. These three factors have been shown to have satisfactory coefficients of internal reliability; 0.82, 0.78 and 0.67, respectively (Orford et al., 2001). The 30 highest loading statements on these three factors make up the short version of the Coping Questionnaire. The short version was used in the current study as the length of the questionnaire pack was an important consideration for health volunteers.

The short version of the Coping Questionnaire (Appendix A) asks individuals to rate the frequency with which they have engaged in 30 specified behaviours in the past
three months, all of which are related to a family member’s alcohol or drug use. The
behaviours reflect one of three coping factors: 14 items relate to ‘engaged’ coping
strategies, 9 to ‘tolerant’ strategies and 7 to ‘withdrawal’ strategies. The four response
options are “no” (scoring 0), “once or twice” (scoring 1), “sometimes” (scoring 2) and
“often” (scoring 3).

An overall score is obtained showing the frequency with which all coping behaviours
have been used (range 0 to 90) as well as scores reflecting the frequencies of the
behaviours related to the three different coping strategies. Two items contributing to
the withdrawal scale are reversed when scoring (one of which also contributes to the
engaged scale). The ranges of the scores for the three coping subscales are 0 to 42 for
the engaged scale, 0 to 27 for the tolerant scale and 0 to 24 for the withdrawal scale.
The three subscales of the Coping Questionnaire are not mutually exclusive, so it is
possible to gain scores reflecting a frequent use of all three types of coping behaviour.

The questionnaire was amended by the author so that all questions related to what
behaviours the male partner had engaged in due to his female partner’s problem
drinking (i.e. it was amended so that it was gender and alcohol specific).

The instructions that accompanied the questionnaire (see Appendix A) are those
currently being used in research by the author of the scale and his colleagues.

An open-response question was added to the end of the Coping Questionnaire in the
current study by the author, so that male partners could add any other behaviours they
had engaged in due to their partner’s drinking.
Causal Dimensions Scale (Russell, 1982)

The Causal Dimensions Scale was designed to assess a person’s perception of the causes that they have stated for an event or behaviour. As shown in Appendix B, the scale has nine questions that cover three sub-scales measuring causal attributions in terms of the ‘locus of causality’ (whether the cause is internal or external), ‘stability’ (whether the cause is permanent or variable) and ‘controllability’ (whether the cause is controllable or uncontrollable). For each question respondents are asked to rate an aspect of the causality on a nine-point Likert scale that is anchored by verbal statements. The scale provides separate scores for each of the three dimensions; ‘locus of causality’, ‘stability’ and ‘controllability’ (range of scores 3 to 27).

The Causal Dimensions Scale was developed as a general measure of causal dimensions and not for specific use with substance users, but the original has been adapted and used with smokers (Grove, 1993) and with problem drinkers (Kellett, 2002).

The causality and stability dimensions have been shown to have satisfactory coefficients of internal reliability: 0.67 for both dimensions (McAuley et al, 1992). The controllability dimension was reported to have a lower coefficient and this led to a revision of the Causal Dimensions Scale (McAuley et al., 1992) such that attributions of controllability were split into personal control and external control. In the present study, the participants were asked to think about the main cause of their female partner’s drinking problem. Therefore in this context, personal control would refer to that of the female partner rather than the participant. It seemed that this could
have been confusing to participants, so the original version of the Causal Dimensions Scale (Russell, 1982) was used in the current study as shown in Appendix B.

In the present study, the participants were instructed to write down what in their view was the main cause for their partner’s drinking problem and then to answer the nine questions rating this cause along the three dimensions of ‘locus of causality’, ‘stability’ and ‘controllability’.

The Likert scale used in the Causal Dimensions Scale has nine numbered points. In the version presented by Russell (1982), on some questions the numbers ran 1 to 9 and on others in the reverse order. McAuley et al. (1992) presented the Causal Dimensions Scale with all the Likert scales being in the same numbered order. Kellett (2002) found that a consistent presentation of the numbers on the Likert scale was more acceptable to participants, so therefore this procedure was used in the current study.

In a pilot study, Kellett (2002) also found that the first item on the Causal Dimensions Scale was conceptually difficult for respondents to understand. Therefore she presented a simpler item first. This approach was also adopted in the current study so that items 1 and 7 were substituted for each other.

In the present study the verbal anchors of the Likert scale were amended from those presented by Russell (1982) so that they referred to the third person (the female partner) rather than the first person (the male partner).
Questions devised for this study

Questions were devised for the present study to collect demographic information (Appendix C). These included questions asking about age and employment status for the male partners as well as the female problem drinkers and a question asking how long the male partner felt the female’s drinking had been problematic in years and months (this was converted into months for the analysis).

Male partners were asked to rate their agreement with the statement that their female partner had a problem with alcohol on a visual analogue scale, where 10 was complete agreement and 0 complete disagreement. When printed, the line of the visual analogue scale was 10.3cm long, so the scores were adjusted to give a rating out of 10.

Male partners were asked about the support they themselves had accessed to help them cope with their partner’s drinking, and if they smoked cigarettes, whether they had ever smoked more than usual in an attempt to cope. They were also asked whether they had ever drunk more than usual in an attempt to cope and asked to give an estimate of their typical weekly alcohol consumption using a one-week diary format (Appendix C). This is seen as an appropriate way to gain a measure of alcohol consumption (Redman, Sanson-Fisher, Wilkinson, Fahey & Gibberd, 1987; Werch, 1990).

From the information given on the one-week drink diary, a total number of units of alcohol was calculated (see Appendix D for the conversion chart used for this purpose). Where a participant reported that he drank for example 2-3 pints of beer, the mean was taken (in this example, 2½ pints) and converted into units of alcohol.
Researchers have used different levels of drinking to distinguish between light and heavy drinkers. For example, Werch (1990) categorised heavy drinkers as those who reported having more than 7 drinks per week and Redman (1987) more than 28 drinks per week. The current government guidelines on alcohol consumption are taken from the *Sensible Drinking* report (Department of Health, 1995) which stated that men should not exceed 4 units of alcohol a day, this equating to 28 units a week. Therefore the participants in this study were seen as ‘heavy’ drinkers if they reported drinking more than 28 units of alcohol in a typical week.

Appendix E shows the general instructions that were presented at the front of the questionnaire pack.

**Procedure**

**Pilot Study**

The questionnaire pack was initially piloted with work colleagues to ensure that the questions, instructions and layout were clear. To check the questionnaire pack’s acceptability it was then piloted with two male partners of female problem drinkers who were in contact with Service B. Following the pilot study, one minor amendment was made to the wording of the question asking how long the female’s drinking had been problematic. The instruction to ‘put 0 if you don’t feel she has a problem’ was added.
Recruitment of participants

The recruitment of participants took place between August 2002 and April 2003. The sample was recruited through two NHS specialist substance misuse services (Services A and B) and through one non-statutory alcohol service (Service C). All services were community-based and the NHS services were multi-disciplinary.

Face-to-face meetings were held at the request of the principal investigator with the clinicians in both of the NHS services to identify females who had been referred due to problems with their alcohol consumption. The clinicians then identified which of those females had male partners.

Some females were excluded due to the clinician’s knowledge of their circumstances. Amongst the reasons for exclusion at this point was the nature of the female’s relationship with her partner (e.g. where the relationship was breaking down) and serious mental or physical-ill health of the female or her partner that would have made participation difficult. Clinicians also excluded those females for whom it was known that their male partner was currently receiving treatment for his own problem drinking.

For those females who were identified as having a male partner and for whom it was felt appropriate to approach them about the study, the clinician made the initial contact with the female problem drinker and gave her the Female Service-user Information Leaflet (Appendix F). At this stage the clinician sought verbal consent for the principal investigator to approach the female problem drinker.
Where possible, the principal investigator met with the female problem drinker when the clinician was also present. At this time, any questions about the study were answered and the study discussed. The female clients also had the opportunity to look at the questionnaire pack that would be sent to their male partner. Written consent was then sought from the female client (see Appendix G for the Female Service-user Consent Form). Those females who gave consent and were willing to give contact details for their male partner were asked to speak to him to gain his verbal consent to have his details passed on to the principal investigator.

Where it was not possible for the principal investigator to meet with the female problem drinker, the clinician gave the female client the Female Patient Information Leaflet which included details of how the principal investigator could be contacted if the female client had any questions about the study or required further information. The clinician then sought written consent from the female client for her male partner to participate in the study.

Where possible the principal investigator met with the female problem drinker to gain contact details for their male partner. Where this was not possible, the clinician gained these details and communicated them in writing to the researcher.

Where the female problem drinker did not give her consent for her male partner to participate, or where the male did not want to have his details passed on, no further action was taken and these people were excluded from the study.
Where consent and contact details had been given by the female problem drinker, the male partner was sent a questionnaire pack by post. This included a letter of introduction (Appendix H), the Male Participant Information Leaflet (Appendix I), the Questionnaire Pack and a freepost addressed envelope. In some cases the female problem drinker offered to take the questionnaire pack and to pass it on to her partner directly. In two cases the principal investigator met with the male partner and was present when they completed the questionnaire pack whilst accompanying clinicians on home visits.

Those male partners who wished to participate were asked to complete the questionnaire pack and return it in the provided envelope. Those male partners who did not wish to participate were asked to return the uncompleted questionnaire pack in the freepost envelope to be counted as a non-response.

Those who did not return a completed questionnaire pack (or blank questionnaire to indicate that they did not wish to participate) within two weeks were sent a reminder letter (see Appendix J) and a further copy of the questionnaire pack. Where the female problem-drinker had taken the questionnaire pack to pass on to her partner, the reminder letter was passed on to her by the clinician.

No further contact was made by the researcher with either the female patients or their male partners.
Direct recruitment of male partners

The non-statutory alcohol service (Service C) had a member of staff who worked with ‘third parties’; concerned families and friends of problem drinkers. This clinician was working with a male partner who was therefore recruited directly and not via the female problem drinker. In this case the clinician gave the male partner the Male Participant Information Leaflet (Appendix I) and sought verbal consent for him to be sent a questionnaire pack.

Compensation

Participants who returned a completed questionnaire pack were sent a £10 shop voucher to compensate the time spent filling in the questionnaire and to say thank you for their participation. Appendix K shows the part of the questionnaire pack that related to this compensation. Participants had a choice of three different shop vouchers. The three shops were chosen as ones where it was not possible to buy alcohol, as it was felt this would have been unethical (McKeganey, 2001). The money for this compensation came from a research fund from Service A.

Ethical approval

The study was first approved by a University of Leicester Research and Assessment committee. Approval was then sought from the Leicestershire Research Ethics Committee and the Southern Derbyshire Local Research Ethics Committee.

One of the committees was concerned that the shop voucher was being used as an enticement for people to take part in the study. When it was explained that there was no mention of the voucher in the information leaflets, and that information about the
compensation of participants appeared only at the end of the questionnaire pack, the committee was satisfied and approved the research procedure. See Appendices L and M for letters of approval from the ethics committees.

Ethical approval to recruit participants through the non-statutory service (Service C) was sought separately (see Appendix N for this letter of approval).
CHAPTER THREE - RESULTS

Completed questionnaires were returned from 28 male partners of female problem drinkers.

Coping Questionnaire (Orford, 1996)

Hypothesis 1: Male partners of female problem drinkers would report using more than one type of coping behaviour.

Descriptive analysis

All 28 male partners completed the Coping Questionnaire (Appendix A). This questionnaire gives scores on the three subscales of engaged, tolerant and withdrawal coping, as well as a total coping score. Table 5 shows the mean scores, standard deviations and ranges for the total coping score and the three subscales.

Table 5 – Mean scores, standard deviations and ranges of the total coping score and the three coping subscales of the Coping Questionnaire for N=28.

<table>
<thead>
<tr>
<th></th>
<th>Mean scores</th>
<th>Standard deviation</th>
<th>Possible range</th>
<th>Observed range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total scores</td>
<td>Item mean scores</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total coping</td>
<td>40.29</td>
<td>1.34</td>
<td>18.96</td>
<td>0-90</td>
</tr>
<tr>
<td>Engaged coping</td>
<td>20.64</td>
<td>1.47</td>
<td>11.58</td>
<td>0-42</td>
</tr>
<tr>
<td>Tolerant coping</td>
<td>11.43</td>
<td>1.27</td>
<td>5.71</td>
<td>0-27</td>
</tr>
<tr>
<td>Withdrawal coping</td>
<td>8.07</td>
<td>1.01</td>
<td>5.63</td>
<td>0-24</td>
</tr>
</tbody>
</table>
The item mean score gives a score that is adjusted to allow for the fact that there were different numbers of questions relating to each subscale. These scores are comparable across the subscales and show that the male partners reported using engaged coping behaviours most frequently and using withdrawal coping scores least frequently. All male partners reported using more than one type of coping behaviour which supports Hypothesis 1.

**Additional comments**

At the end of the Coping Questionnaire a space was left for the male partners to add any other things they had done because of their partner’s drinking. Thirteen male partners (46.4%) added 17 additional comments. Table 6 shows the number of comments that were seen by the author to relate to each of the three ways of coping presented by Orford et al. (1998).

**Table 6 – Number of additional comments related to each type of coping behaviour.**

<table>
<thead>
<tr>
<th>Type of coping behaviour</th>
<th>Number of comments relating to this type of coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged</td>
<td>9</td>
</tr>
<tr>
<td>Tolerant</td>
<td>2</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>2</td>
</tr>
<tr>
<td>Mixed</td>
<td>3</td>
</tr>
</tbody>
</table>

Where a behaviour was seen to reflect more than one of these ways of coping, it was considered of ‘mixed’ type. Appendix O gives the full text of these comments and the
type of coping to which they were seen to relate by the author, using the typologies presented by Orford et al. (1992; 1998). Two comments made were not seen as reflecting a coping behaviour: one male partner wrote that he “could have been more supportive” of his female partner’s work and family life and another that recently his partner’s alcohol consumption had “been a lot less”. From Table 6 it can be seen that the majority of the additional comments made by the male partners related to engaged coping behaviours.

Comparison with a sample of female partners

Hypothesis 2: There would be differences between the reported coping behaviours of the male partners of female problem drinkers in the current study and the female partners of male problem drinkers in a comparison sample.

Hypothesis 2.1: Male partners in the current study would report a lower frequency use of engaged coping behaviours when compared to female partners in a comparison sample.

Hypothesis 2.2: Male partners in the current study would report using a higher frequency of withdrawal coping behaviours when compared to female partners in a comparison sample.

Comparison samples

Orford and colleagues have carried out a series of studies using the Coping Questionnaire with a range of family members. As a comparison sample the author
had planned to use data presented by Hurcom, Copello and Orford (1999), who reported a study which looked at the coping behaviours of a sample of 29 female partners of male problem drinkers. Beyond a direct comparison it was not possible to use statistical analysis to compare this data with that from the current study on the grounds that the data from the Coping Questionnaire in the current study was not normally distributed (therefore requiring non-parametric methods of analysis), and the Hurcom et al. study only reported mean scores (therefore requiring parametric methods of analysis).

Amongst their other studies using the Coping Questionnaire, Orford et al. (1998) reported a larger study looking at the coping behaviours of family members in Mexico and England. The author was given access to the Coping Questionnaire data on the sub-sample of 27 English female partners of male problem drinkers which was part of this study. The author was given the raw data of the Coping Questionnaire scores, therefore permitting statistical analysis between the female partner sample and the male partner sample from the current study.

*Comparison with the Hurcom et al. (1999) sample*

It was expected that there would be differences in the Coping Questionnaire scores of the male partners in the current study and the female partners in the Hurcom et al. (1999) study. Table 7 shows the item mean Coping Questionnaire scores of the male partners in the current study and the female partners in the Hurcom et al. study.

The item mean scores suggest that the male partners in the current study reported using less coping behaviours than the female partners in the Hurcom et al. (1999)
Table 7 – The mean item mean scores of the three subscales of the Coping Questionnaire of the male partners in the current study and the female partners in the Hurcom et al. (1999) study.

<table>
<thead>
<tr>
<th></th>
<th>Engaged coping</th>
<th>Tolerant coping</th>
<th>Withdrawal coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male partners</td>
<td>1.47</td>
<td>1.27</td>
<td>1.01</td>
</tr>
<tr>
<td>Female partners</td>
<td>1.81</td>
<td>1.32</td>
<td>1.86</td>
</tr>
</tbody>
</table>

study on the three subscales of the Coping Questionnaire, which gives some support to Hypothesis 2. These differences were most pronounced on the withdrawal coping score. Hypothesis 2.2 predicted that the male partners would report a more frequent use of withdrawal coping behaviours, but Table 7 shows that in the comparison between the two groups, the observed difference was in the opposite direction. As stated above it was not possible to carry out any analysis to see if these differences were significant.

Comparison with the Orford et al. (1998) sample

Table 8 shows the mean Coping Questionnaire scores for the male partners in the current study and the female partners in the Orford et al. (1998) sample. This shows that the two samples had comparable means for the total coping score and engaged coping subscale scores. Similar to the comparison with the female partners from the Hurcom et al. (1999) study, the female partners in the Orford et al. (1998) sample had higher withdrawal coping scores than the male partners, which leads to a rejection of Hypothesis 2.2.
Table 8 — Means and standard deviations of the Coping Questionnaire scores of the male partners in the current study and the female partners in the Orford et al. (1998) sample.

<table>
<thead>
<tr>
<th></th>
<th>Total coping</th>
<th>Engaged coping</th>
<th>Tolerant coping</th>
<th>Withdrawal coping</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male partners</strong></td>
<td>$M = 40.29$</td>
<td>$M = 20.64$</td>
<td>$M = 11.43$</td>
<td>$M = 8.07$</td>
</tr>
<tr>
<td>($N=28$)</td>
<td>$SD = 18.96$</td>
<td>$SD = 11.58$</td>
<td>$SD = 5.71$</td>
<td>$SD = 5.63$</td>
</tr>
<tr>
<td><strong>Female partners</strong></td>
<td>$M = 41.41$</td>
<td>$M = 20.67$</td>
<td>$M = 9.11$</td>
<td>$M = 12.48$</td>
</tr>
<tr>
<td>($N=27$)</td>
<td>$SD = 10.63$</td>
<td>$SD = 6.23$</td>
<td>$SD = 5.48$</td>
<td>$SD = 4.80$</td>
</tr>
</tbody>
</table>

The total coping and engaged coping scores of the male partners from the current study had much higher standard deviations than those of the female partners in the Orford et al. (1998) study, indicating a greater spread of scores and therefore a greater variance in how they responded. This is illustrated by means of box-and-whisker plots. Figure 3 shows the spread of scores for the male and female partner samples for the total coping and Figure 4 shows the spread of scores for the engaged coping for the two samples. (Note: SPSS creates a graph based on equal groups. The one omitted case from the group of male partners did not significantly alter the appearance of the graphs.)
Figure 3 – Spread of scores of the male and female partner samples’ total coping scores.

Figure 4 – Spread of scores of the male and female partner samples’ engaged coping scores.

The male partners had a higher mean score on the tolerant coping subscale, suggesting a higher frequency of using tolerant coping behaviours than the female partners, and a lower mean score on the withdrawal coping score, suggesting a lower frequency of
using withdrawal coping behaviours than the female partners. This provided limited support for Hypothesis 2 that stated that there would be differences in the Coping Questionnaire scores of the male and female partner samples.

For both the male partners and the female partners, the tolerant and withdrawal coping scores have similar standard deviations, indicating that the female partners' tolerant scores were generally lower and their withdrawal scores generally higher, than those of the male partners.

Between groups analysis

To investigate whether the differences in the Coping Questionnaire scores between the male partner and female partner samples were significant, a between groups analysis was carried out. Because the data from the Coping Questionnaire was not normally distributed, a distribution-free method of analysis was used (Bland, 1995; Clark-Carter, 1997). The Mann-Whitney U test was used as it is also appropriate for groups of unequal size (Bland, 1995; Clark-Carter, 1997).

The Mann-Whitney U test assumes that there is homogeneity of variance between the two groups that are going to be compared (Clark-Carter, 1997). Analysis of this data showed that the variances of the Coping Questionnaire scores were homogeneous (see Appendix P for this analysis). For this and all subsequent analyses, data was analysed using the SPSS statistical package for Windows. Table 9 shows the results of this Mann-Whitney U test.
As shown in Table 9, the two samples differed significantly on the withdrawal coping scores, but not on the other coping subscales or the total coping score. The mean withdrawal coping score for the male partners was 8.07 (SD=5.63) and the mean for the female partner sample was 12.48 (SD=4.80), showing the male partners reportedly used a lower frequency of withdrawal coping behaviours than female partners. Therefore there was limited support for Hypothesis 2 that the male and female partner samples would gain different scores on the Coping Questionnaire. Hypotheses 2.1 and 2.2 were not supported as there was no significant difference in the engaged coping scores, and the difference in the withdrawal coping scores was not in the expected direction.

Table 9 — Results of the Mann-Whitney U test comparing the Coping Questionnaire scores of the male and female partner samples.

<table>
<thead>
<tr>
<th>Total coping score</th>
<th>Engaged coping score</th>
<th>Tolerant coping score</th>
<th>Withdrawal coping score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difference</td>
<td>$U = 377.500$</td>
<td>$U = 372.500$</td>
<td>$U = 285.000$</td>
</tr>
<tr>
<td>between male and</td>
<td>$p = 0.993$</td>
<td>$p = 0.926$</td>
<td>$p = 0.116$</td>
</tr>
<tr>
<td>female partners</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**$p < 0.01$ (two-tailed test)**

Gardner and Altman (1989) suggested that confidence limits should be presented to show how a sample may relate to the population from which it comes. Unfortunately it is not possible to calculate a confidence interval based on the Mann-Whitney U test when data is not of interval type (Bland, 1995).
Comparison of the three samples

Hurcom et al. (1999) reported the Coping Questionnaire scores for a sample of 29 female partners, the Orford et al. (1998) study contained a sample of 27 female partners and the current study had a sample of 28 male partners. Table 10 shows the mean item scores for each of these three samples.

Table 10 – Mean item scores on the Coping Questionnaire for the three samples of partners of problem drinkers.

<table>
<thead>
<tr>
<th></th>
<th>Engaged coping score</th>
<th>Tolerant coping score</th>
<th>Withdrawal coping score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male partners in the current study (N=28)</td>
<td>1.47</td>
<td>1.27</td>
<td>1.01</td>
</tr>
<tr>
<td>Female partners in the Orford et al. (1998) study (N=27)</td>
<td>1.48</td>
<td>1.01</td>
<td>2.08</td>
</tr>
<tr>
<td>Female partners in the Hurcom et al. (1999) study (N=29)</td>
<td>1.81</td>
<td>1.32</td>
<td>1.86</td>
</tr>
</tbody>
</table>

There was little correspondence between the Coping Questionnaire scores of the two samples of female partners of male problem drinkers. In terms of the engaged coping scores, the female partners from the Orford et al. (1998) study and the male partners in the current study had very similar scores, and the female partners in the Hurcom et al. (1999) study reported using more engaged coping behaviours. The male partners in the current study reported using a frequency of tolerant coping behaviours that was more than the female partners in the Orford et al. sample, but less than the female partners in the Hurcom et al. study. The only consistent gender difference was that the
male partners reported using less withdrawal coping behaviours than both the samples of female partners.

The above comparison of the male partners in the current study with two samples of female partners suggests that the reported differences may have been due to factors other than gender.

Comparison of ages

To explore other factors that may explain the differences in the Coping Questionnaire scores, the ages of the male partners in the current study and the female partners in the Orford et al. (1998) study were compared. Data was not available to include the sample of female partners from the Hurcom et al. (1999) study in this comparison. The ages of the female partners of male problems drinkers in the Orford et al. sample and the male partners of female problem drinkers in the current study were unfortunately collected across different age ranges. The ages of the male problem drinkers in the Orford et al. sample were given in exact ages, therefore it was possible to put them into the same age ranges as those used in the current study. Table 11 shows the age ranges of the male partners in the current study and Table 12 shows those of the female partners in the Orford et al. sample.

Tables 11 and 12 show that the majority of the male partners in the current study were over the age of 45. The female partners in the Orford et al. (1998) sample tended to be younger and the majority were under the age of 40. Due to the fact that the ages were recorded in different age ranges, it was not possible to analyse these differences to see if they were significant.
Table 11 - Age ranges of the male partners in the current study.

<table>
<thead>
<tr>
<th>Age ranges in years</th>
<th>Numbers (%) of male partners (N=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - 34</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td>35 - 44</td>
<td>4 (14.3)</td>
</tr>
<tr>
<td>45 - 54</td>
<td>14 (50.0)</td>
</tr>
<tr>
<td>55 - 64</td>
<td>9 (32.1)</td>
</tr>
<tr>
<td>66 +</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 12 - Age ranges of the female partners in the Orford et al. (1998) study.

<table>
<thead>
<tr>
<th>Age ranges in years</th>
<th>Numbers (%) of female partners (N=27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 years and under</td>
<td>1 (3.7)</td>
</tr>
<tr>
<td>21 - 30</td>
<td>4 (14.8)</td>
</tr>
<tr>
<td>31 - 40</td>
<td>10 (37.0)</td>
</tr>
<tr>
<td>41 - 50</td>
<td>8 (29.6)</td>
</tr>
<tr>
<td>51 +</td>
<td>4 (14.8)</td>
</tr>
</tbody>
</table>

Table 13 shows the ages of the female drinkers in the current study and the male drinkers in the Orford et al. (1998) sample. This shows that the majority of the male drinkers in the Orford et al. sample were under the age of 45. The female drinkers in the current study tended to be older and the majority were over the age of 45. This is consistent with the differences in ages seen in the samples of male and female partners reported above.
Table 13 – Numbers and percentages of female problem drinkers in the current study and male problem drinkers in the Orford et al. (1998) sample, in each of the age ranges.

<table>
<thead>
<tr>
<th>Age ranges in years</th>
<th>Numbers (%) of female drinkers</th>
<th>Numbers (%) of male drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=28</td>
<td>N=27</td>
</tr>
<tr>
<td>25-34</td>
<td>2 (7.1)</td>
<td>7 (25.9)</td>
</tr>
<tr>
<td>35-44</td>
<td>5 (17.9)</td>
<td>11 (40.7)</td>
</tr>
<tr>
<td>45-54</td>
<td>19 (67.9)</td>
<td>6 (22.2)</td>
</tr>
<tr>
<td>55-64</td>
<td>1 (3.6)</td>
<td>2 (7.4)</td>
</tr>
<tr>
<td>66+</td>
<td>1 (3.6)</td>
<td>1 (3.7)</td>
</tr>
</tbody>
</table>

To see if the differences in the ages of the female problem drinkers in the current study and the male problem drinkers in the Orford et al. (1998) sample were significantly different, a Mann-Whitney U test was carried out, based on assigning numbers to the different age ranges and the frequencies with which these occurred. The Mann-Whitney U test assumes homogeneity of variance between the two groups to be compared and Appendix Q gives details of how this assumption was met. The U test showed that the difference in ages between the two groups was significant at the 0.05 level (U=236.000, p=0.011, two-tailed test), with the problem drinkers in the current study being significantly older than the problem drinkers in the Orford et al. study. This suggests that age may play a role in the observed differences.
Causal Dimensions Scale

Hypothesis 3.1: Male partners would make a high number of internal attributions as to the cause of the female’s problem drinking.

Hypothesis 3.2: Where male partners made attributions indicating that they saw the cause of the problem drinking as unchangeable, they would report a higher frequency of withdrawal coping behaviours than those male partners who saw the cause as changeable.

Hypothesis 3.3: Where male partners made attributions indicating that they saw the cause of the problem drinking as unchangeable, they would report a higher frequency of tolerant coping behaviours than those male partners who saw the cause as changeable.

Hypothesis 3.4: Where male partners made attributions indicating that they saw the cause of their female partner’s drinking as changeable, they would report using more engaged coping behaviours than those male partners who saw the cause as unchangeable.

Descriptive analysis

One male partner did not complete the Causal Dimensions Scale (Appendix B) giving a sample size of 27 for this measure.
Reasons for drinking

Male partners were asked to record what they perceived to be the main reason for their partner’s problem drinking. One male partner stated that he did not know why his partner drank and did not complete this section of the questionnaire. Another male partner did not state a reason but did complete this scale. Table 14 summarises the main reasons given by the male partners and Appendix R gives the full text of these reasons.

Table 14 — Main cause or reason given by the male partners for their female partner’s problem drinking.

<table>
<thead>
<tr>
<th>Main reason given</th>
<th>Number (%) of male partners who gave the reason, n=26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>8 (30.8)</td>
</tr>
<tr>
<td>Low self-esteem / self confidence</td>
<td>5 (19.2)</td>
</tr>
<tr>
<td>Poor family / marital relationships</td>
<td>4 (23.1)</td>
</tr>
<tr>
<td>Past emotional / family problems</td>
<td>3 (15.4)</td>
</tr>
<tr>
<td>Stress</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>To block things out</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>Addiction / habit</td>
<td>1 (3.8)</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>1 (3.8)</td>
</tr>
</tbody>
</table>

Table 14 shows that a large number of the male partners felt that their female partner drank because she was depressed (30.8%). Low self-esteem or self confidence, poor family or marital relationships and past emotional or family problems were the next
most common reported reasons. Only one male reported that he felt the main reason for his partner’s drinking was due to an addiction or habit.

Questionnaire scores

Table 15 shows the means, standard deviations and range of scores for the 27 male partners who completed the Causal Dimensions Scale. The range of scores on each bipolar dimension of the Causal Dimensions Scale was 3 to 27, giving a median of 15. Scores above the median were seen as attributions that the locus of the cause was internal, that the cause was stable and that it was controllable. Scores below the median were seen as attributions that the locus of the cause was external, that the cause was unstable and that it was uncontrollable.

Table 15 – Means, standard deviations and range of scores for the three dimensions of the Causal Dimensions Scale for n=27.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard deviation</th>
<th>Observed</th>
<th>Possible range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locus of causality</td>
<td>17.74</td>
<td>4.13</td>
<td>9 – 26</td>
<td>3 – 27</td>
</tr>
<tr>
<td>Stability</td>
<td>15.19</td>
<td>4.44</td>
<td>8 – 24</td>
<td>3 – 27</td>
</tr>
<tr>
<td>Controllability</td>
<td>14.96</td>
<td>5.54</td>
<td>3 – 25</td>
<td>3 – 27</td>
</tr>
</tbody>
</table>

Table 15 shows that the mean scores on the Causal Dimensions Scale were close to the median score, therefore the male partners did not rate the cause of the female’s drinking in a consistent direction. This would be expected due to the different reasons they gave for their female partner’s drinking.
Table 16 shows the numbers of male partners gaining high and low mean scores on each of the three causal dimensions. One of the male partners did not complete this questionnaire, and where numbers do not add up to 27, the remaining male partners scored a mean of 15 (neither high nor low) and were therefore excluded.

### Table 16 – Numbers of male partners gaining high and low scores on each of the three causal dimensions

<table>
<thead>
<tr>
<th></th>
<th>Number of male partners scoring above 15</th>
<th>Number of male partners scoring below 15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Locus of causality</strong></td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td><strong>Stability</strong></td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td><strong>Controllability</strong></td>
<td>12</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 16 shows that on the locus of causality dimension, the majority of the male partners gained high scores indicating that they felt the cause of their female partner’s drinking was internal as opposed to external. This supports Hypothesis 3.1 that male partners would make more internal attributions of the cause of their partner’s drinking due to the actor-observer difference (Munton et al., 1999). Equal numbers of the male partners gained high and low scores on the stability dimension, and similar numbers gained high and low scores on the controllability dimension.

**Between groups analysis**

Hypotheses 3.2 and 3.3 stated that where male partners made attributions that the cause of the female’s drinking was stable and uncontrollable (i.e. that it could not change), the male partners would use more withdrawal and tolerant coping
behaviours, and Hypothesis 3.4 stated that where the cause was seen as unstable and controllable (i.e. that it could change) the male partners would use more engaged coping. Only five male partners rated the cause of their partner's drinking as both stable and uncontrollable (i.e. unchangeable) and only four rated the cause as both unstable and controllable (i.e. changeable).

Table 17 shows the means and standard deviations of the Coping Questionnaire scores for the two groups described above. It shows that the total coping scores were very similar, but that the group making unstable and controllable attributions had a wider spread of scores. The group making unstable and controllable attributions (i.e. changeable) had a higher engaged mean coping score, and lower tolerant and withdrawal mean coping scores. This trend supports Hypotheses 3.2, 3.3 and 3.4.

<table>
<thead>
<tr>
<th>Total coping score</th>
<th>Engaged coping score</th>
<th>Tolerant coping score</th>
<th>Withdrawal coping score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unchangeable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M = 34.80</td>
<td>M = 13.80</td>
<td>M = 12.00</td>
<td>M = 10.40</td>
</tr>
<tr>
<td>n=5</td>
<td>SD = 15.87</td>
<td>SD = 10.26</td>
<td>SD = 6.47</td>
</tr>
<tr>
<td>Changeable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M = 34.25</td>
<td>M = 19.25</td>
<td>M = 8.75</td>
<td>M = 8.25</td>
</tr>
<tr>
<td>n=4</td>
<td>SD = 22.94</td>
<td>SD = 13.15</td>
<td>SD = 5.56</td>
</tr>
</tbody>
</table>

To see if the differences shown above were significant, a Mann-Whitney U test was carried out. Because the data from the scores on these two measures was not normally
distributed a distribution-free method of analysis was used (Bland, 1995; Clark-Carter, 1997). The Mann-Whitney U test was used as it is also appropriate for groups of unequal size (Bland, 1995; Clark-Carter, 1997). The Mann-Whitney U test assumes that there is homogeneity of variance between the two groups that are going to be compared (Clark-Carter, 1997). Analysis of this data showed that the variances of the Coping Questionnaire scores were homogeneous (see Appendix S for this analysis).

Table 18 presents the results of the Mann-Whitney U test looking at the Coping Questionnaire scores of those who made stable and uncontrollable (i.e. unchangeable) attributions about the cause of the drinking and those who made unstable and controllable (i.e. changeable) attributions about the cause of the female partner's drinking. The U test results show that there were no significant differences in the Coping Questionnaire scores for these two groups. Therefore Hypotheses 3.2, 3.3 and 3.4 were not supported.

Table 18 – Results of the Mann-Whitney U test comparing the Coping Questionnaire scores of those who made 'changeable' and 'unchangeable' attributions.

<table>
<thead>
<tr>
<th></th>
<th>Total coping score</th>
<th>Engaged score</th>
<th>Tolerant score</th>
<th>Withdrawal score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changeable (n=5) vs</td>
<td>U = 10.000</td>
<td>U = 6.000</td>
<td>U = 7.500</td>
<td>U = 8.000</td>
</tr>
<tr>
<td>unchangeable (n=4)</td>
<td>p = 1.000</td>
<td>p = 0.327</td>
<td>p = 0.539</td>
<td>p = 0.624</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Male partners’ alcohol consumption

Hypothesis 4.1: There would be a high number of heavy drinking male partners in the sample in the current study.

Hypothesis 4.2: Where male partners were classed as heavy drinkers they would report a higher frequency of tolerant coping behaviours than those with a lower alcohol consumption.

Hypothesis 4.3: Male partners who were classed as heavy drinkers would gain lower Coping Questionnaire scores than those with a lower alcohol consumption.

Descriptive analysis

Three male partners reported that they did not drink alcohol at all. The information given on the drinking diary of a typical week’s alcohol consumption (Appendix C), showed that the 25 male partners who did drink, drank an average of 16.44 units of alcohol a week (range 2 to 46 units, SD=10.40).

Figure 5 shows a box-and-whisker plot of the male partners’ reported alcohol consumption for a typical week. This shows that there was an outlier; one participant whose alcohol consumption was more than 1.5 times the box-length above the upper edge of the box. This male partner reported drinking 46 units of alcohol in a typical week. If this subject was excluded from the analysis, the mean number of units of alcohol drunk in a typical week was 13.52 (n=24, range 0 to 30 units, SD=9.41).
There was no reason to believe that the outlying data point was inaccurate, therefore it was not excluded from further analysis (Bland, 1995).

![Box-and-whisker plot showing the male partners' reported alcohol consumption for a typical week.](image)

_Hypothesis 4.1 stated that there would be a high number of heavy drinkers amongst the male partners. Male partners were classified as heavy drinkers if they exceeded the recommended 28 units of alcohol a week (Department of Health, 1995), and light drinkers if they drank less than this. Out of the 25 who reported to drink alcohol, four (16.0%) were classified as heavy drinkers and 21 (84.0%) as light drinkers. Therefore there was little support for Hypothesis 4.1 as heavy drinkers were in the minority._

**Between groups analysis**

Table 19 shows the means, medians and standard deviations of the Coping Questionnaire scores for the 3 different levels of alcohol consumption: abstinent; light
drinkers; and heavy drinkers. This shows that for the total coping score, the abstinent and light drinkers had similar mean scores, and that these were higher than the score of the heavy drinkers, showing that the heavy drinkers reported a less frequent use of all coping behaviours. This provides partial support to Hypothesis 4.3 that the heavy drinkers would report a lower frequency of coping behaviours than those classed as abstinent or light drinkers.

**Table 19 – Means, medians and standard deviations of the Coping Questionnaire scores for the different levels of alcohol consumption.**

<table>
<thead>
<tr>
<th></th>
<th>Total coping</th>
<th>Engaged coping</th>
<th>Tolerant coping</th>
<th>Withdrawal coping</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abstinent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=3)</td>
<td>M = 43.67</td>
<td>M = 17.33</td>
<td>M = 15.00</td>
<td>M = 12.67</td>
</tr>
<tr>
<td></td>
<td>Median=40.00</td>
<td>Median=12.00</td>
<td>Median=15.00</td>
<td>Median=15.00</td>
</tr>
<tr>
<td></td>
<td>SD = 7.23</td>
<td>SD = 11.02</td>
<td>SD = 1.00</td>
<td>SD = 7.77</td>
</tr>
<tr>
<td><strong>Light drinkers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=21)</td>
<td>M = 42.62</td>
<td>M = 22.43</td>
<td>M = 11.67</td>
<td>M = 7.76</td>
</tr>
<tr>
<td></td>
<td>Median=45.00</td>
<td>Median=23.00</td>
<td>Median=12.00</td>
<td>Median=6.00</td>
</tr>
<tr>
<td></td>
<td>SD = 20.20</td>
<td>SD = 12.01</td>
<td>SD = 6.03</td>
<td>SD = 5.63</td>
</tr>
<tr>
<td><strong>Heavy drinkers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=4)</td>
<td>M = 25.50</td>
<td>M = 13.75</td>
<td>M = 7.50</td>
<td>M = 6.25</td>
</tr>
<tr>
<td></td>
<td>Median=29.50</td>
<td>Median=16.00</td>
<td>Median=7.50</td>
<td>Median=6.50</td>
</tr>
<tr>
<td></td>
<td>SD = 11.79</td>
<td>SD = 8.22</td>
<td>SD = 4.04</td>
<td>SD = 2.75</td>
</tr>
</tbody>
</table>

The standard deviation of the total coping score for the light drinkers is large, indicating a wide spread of scores for this group. There was less variance in the engaged coping score across the three groups (partly due to the lower possible range...
of scores). The light drinkers gained the highest engaged coping mean score, indicating that they reported the most frequent use of engaged coping behaviours.

For the tolerant coping score, the heavy drinkers had a lower mean score than the other two groups, indicating that they reported a less frequent use of tolerant coping behaviours. This is contrary to what was expected and does not support Hypothesis 4.2. For the withdrawal coping, the abstinent group had the highest mean score, indicating a higher frequency use of withdrawal coping behaviours amongst this group.

For the total coping and the engaged subscale scores, there were relatively large standard deviations for the abstinent and heavy drinkers, especially when the small sample sizes are taken into consideration. This suggests that the male partners in these groups did not tend to respond in a similar way to each other, and there was no pattern of response according to the level of alcohol consumption.

To see if the differences reported above were significant, a Mann-Whitney U test was carried out. This test assumes homogeneity of variance between the two groups being compared. Analysis of the variances showed that not all data to be compared met these assumptions (see Appendix T for this analysis). Therefore the Mann-Whitney U test was only used where there was homogeneity of variance, and those results are presented below in Table 20.

Table 20 shows that there was a significant difference in the total coping scores and the tolerant coping scores between those who reported being abstinent and those who
were classed as heavy drinkers. For the total coping score, those who were abstinent (n=3) scored a mean of 43.67 (range 39 to 43, SD=7.23) and for those who were heavy drinkers (n=4) the mean was 25.50 (range 9 to 34, SD=11.79). This suggests that those who were abstinent reported a significantly higher frequency of using all coping behaviours than those who were heavy drinkers. This supports Hypothesis 4.3 that stated that the male partners classed as heavy drinkers would report a lower frequency of coping behaviours than those with a lower alcohol consumption.

Table 20 – Mann-Whitney U test comparing the different levels of alcohol consumption and the Coping Questionnaire scores.

<table>
<thead>
<tr>
<th></th>
<th>Total coping</th>
<th>Engaged coping</th>
<th>Tolerant coping</th>
<th>Withdrawal coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinent group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=3) and light drinkers (n=21)</td>
<td>U = 20.500</td>
<td>p = 0.336</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abstinent group</td>
<td>U = 0.000</td>
<td>U = 6.000</td>
<td>U = 0.000</td>
<td>U = 3.000</td>
</tr>
<tr>
<td>(n=3) and heavy drinkers (n=4)</td>
<td>p = 0.032*</td>
<td>p = 1.000</td>
<td>p = 0.031*</td>
<td>p = 0.289</td>
</tr>
<tr>
<td>Light (n=21) and heavy drinkers (n=4)</td>
<td>U = 25.500</td>
<td></td>
<td></td>
<td>U = 37.500</td>
</tr>
<tr>
<td></td>
<td>U = 0.000</td>
<td>U = 6.000</td>
<td>U = 0.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p = 0.220</td>
<td></td>
<td></td>
<td>p = 0.738</td>
</tr>
</tbody>
</table>

❖ analysis not performed as data did not meeting assumptions for the Mann-Whitney U test
* p < 0.05 (two-tailed test)

For the tolerant coping scores, the abstinent group had a mean of 15.00 (range 14 to 16, SD=1.00) and the heavy drinkers had a mean of 7.50 (range 4 to 11, SD 4.04).
This suggests that the abstinent group showed a higher frequency of tolerant coping behaviours than the heavy drinkers. This is the converse to what was expected and does not support Hypothesis 4.2 which stated that the heavy drinkers would be more tolerant of their partner’s drinking and would gain higher tolerant coping scores on the Coping Questionnaire.

No significant differences were seen in the scores on the engaged or the withdrawal coping subscales.

**Perception of female partners’ drinking**

*Hypothesis 5.1*: Where male partners did not see their female partner’s drinking as problematic, they would report a low frequency use of all coping behaviours than those who saw drinking as problematic.

*Hypothesis 5.2*: Male partners who were classed as heavy drinkers would not see their partners drinking as so much of a problem when compared with those with a lower alcohol consumption.

**Descriptive analysis**

Male partners were asked to rate on a 10cm visual analogue scale their agreement with the statement that their female partner had an alcohol problem (see Appendix C). One male partner did not complete this section of the questionnaire. The 27 male partners who did gave a mean rating of 7.74 (range 2.67 to 10.00, SD=1.71) showing that they tended to agree that their female partner had a drinking problem.
Figure 6 shows a box-and-whisker plot of the extent to which the male partners agreed that their female partner’s drinking was problematic. This shows that there were three outlying data points and one extreme data point (where the data point was more than three times the box-length below the lower edge of the box). If these outliers and the extreme data point were excluded from the analysis, there was a mean rating of 8.33 (n=23, range 6.00 to 10.00, SD=0.89). This small standard deviation shows that there was a very narrow range of scores for this subset, indicating that these male partners strongly agreed that their female partner’s drinking was problematic. Again there was no reason to believe that the outlying and extreme data points were inaccurate, therefore they were not excluded from further analysis (Bland, 1995).

Figure 6 - Box-and-whisker plot showing the extent to which the male partners agreed that their partner’s drinking was problematic.

○ denotes outlying data point
* denotes extreme data point
**Correlational analyses**

Where data from the independent variables was continuous, correlational analyses were used to look at the associations between those variables and the dependent variable (Agresti, 1990). There was evidence that the data from the independent variables was not normally distributed, therefore a distribution-free method of analysis was used (Bland, 1995; Clark-Carter, 1997). Kendall’s rank correlation coefficient was chosen over Spearman’s rank correlation coefficient, as it is easier to interpret as a measurement of the strength of a relationship. To allow for the possibility of tied pairs, Kendall’s τb was used (Bland, 1995). In all correlational analyses, two-tailed levels of significance were used (Bland, 1995).

Hypothesis 5.1 stated that those male partners who showed less agreement with the statement that their female partner’s drinking was problematic would report a lower frequency of coping behaviours, as they would not feel there was a problem to be coped with. To investigate this, a correlational analysis was carried out between the perception of the female’s drinking and the Coping Questionnaire scores. The results are presented in Table 21.

Table 21 shows that there were significant positive correlations between the extent to which the male partners agreed that their partner’s drinking was problematic and the total coping score (τb =0.322, p=0.020) and the tolerant coping score (τb =0.328, p=0.021). The correlation between the extent that the male partners agreed that their female partner’s drinking was problematic and the engaged coping score was near to the 0.05 significance level, showing a positive trend (τb=0.273, p=0.051). These results suggest that the more the male partner saw his female partner's drinking as
Table 21 — Kendall’s rank correlation matrix for how much the male partners agreed their female partner’s drinking was a problem and the Coping Questionnaire scores.

<table>
<thead>
<tr>
<th></th>
<th>Extent</th>
<th>Total</th>
<th>Engaged</th>
<th>Tolerant</th>
<th>Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>coping</td>
<td>coping</td>
<td>coping</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>score</td>
<td>score</td>
<td>score</td>
</tr>
<tr>
<td>Extent</td>
<td>$\tau_b = 1.000$</td>
<td>$\tau_b = 0.322^*$</td>
<td>$\tau_b = 0.273$</td>
<td>$\tau_b = 0.328^*$</td>
<td>$\tau_b = 0.027$</td>
</tr>
<tr>
<td></td>
<td>$p = 0.020$</td>
<td>$p = 0.051$</td>
<td>$p = 0.021$</td>
<td>$p = 0.850$</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$\tau_b = 0.322^*$</td>
<td>$\tau_b = 1.000$</td>
<td>$\tau_b = 0.763^{**}$</td>
<td>$\tau_b = 0.699^{**}$</td>
<td>$\tau_b = 0.228$</td>
</tr>
<tr>
<td>coping</td>
<td>$p = 0.020$</td>
<td>$p = 0.000$</td>
<td>$p = 0.000$</td>
<td>$p = 0.096$</td>
<td></td>
</tr>
<tr>
<td>score</td>
<td>$\tau_b = 0.273$</td>
<td>$\tau_b = 0.763^{**}$</td>
<td>$\tau_b = 1.000$</td>
<td>$\tau_b = 0.510^{**}$</td>
<td>$\tau_b = 0.047$</td>
</tr>
<tr>
<td>Engaged</td>
<td>$p = 0.051$</td>
<td>$p = 0.000$</td>
<td>$p = 0.000$</td>
<td>$p = 0.735$</td>
<td></td>
</tr>
<tr>
<td>coping</td>
<td>$\tau_b = 0.328^*$</td>
<td>$\tau_b = 0.699^{**}$</td>
<td>$\tau_b = 0.510^{**}$</td>
<td>$\tau_b = 1.000$</td>
<td>$\tau_b = 0.184$</td>
</tr>
<tr>
<td>score</td>
<td>$p = 0.021$</td>
<td>$p = 0.000$</td>
<td>$p = 0.000$</td>
<td>$p = 0.188$</td>
<td></td>
</tr>
<tr>
<td>Tolerant</td>
<td>$\tau_b = 0.027$</td>
<td>$\tau_b = 0.228$</td>
<td>$\tau_b = 0.047$</td>
<td>$\tau_b = 0.184$</td>
<td>$\tau_b = 1.000$</td>
</tr>
<tr>
<td>coping</td>
<td>$p = 0.850$</td>
<td>$p = 0.096$</td>
<td>$p = 0.735$</td>
<td>$p = 0.188$</td>
<td></td>
</tr>
<tr>
<td>score</td>
<td>$\tau_b = 0.027$</td>
<td>$\tau_b = 0.228$</td>
<td>$\tau_b = 0.047$</td>
<td>$\tau_b = 0.184$</td>
<td>$\tau_b = 1.000$</td>
</tr>
</tbody>
</table>

$^O$ extent that male partners agreed their female partner’s drinking was problematic

*p < 0.05 (two-tailed test)

**p < 0.01 (two-tailed test)
problematic, the more frequently he reported using all coping behaviours and in particular, tolerant coping behaviours. Therefore there was partial support for Hypothesis 5.1.

Table 21 also shows that there were significant correlations between the different coping subscales and the total coping score on the Coping Questionnaire. There were significant positive correlations between the total coping score and the engaged coping subscale ($r_b = 0.763, p = 0.000$) and between the total coping score and the tolerant coping subscale ($r_b = 0.699, p = 0.000$). There was also a significant positive correlation between the tolerant and engaged coping subscales ($r_b = 0.510, p = 0.000$). Hurcom et al. (1999) reported a significant correlation between the engaged and tolerant subscales on the Coping Questionnaire, but did not report any correlations between the subscales and the total coping score.

**Correlations between the independent variables**

Hypothesis 5.2 stated that the more the male partner drank, the less of a problem he would see his female partner’s drinking. Table 22 shows the correlation matrix for the associations between the independent variables with continuous data.

Table 22 shows that there were no significant correlations between the three independent variables. There was no significant correlation between the perceived length of time that the females’ drinking had been problematic and how much the male partners agreed with the statement that their female partner’s drinking was problematic ($r_b = 0.142, p = 0.313$). No significant correlation was found between the male partners’ own alcohol consumption and the length of the female’s drinking
problem ($\tau_b = 0.062, p = 0.659$). There was no significant correlation between how much the male partners drank in a typical week and how much they agreed with the statement that their partner’s drinking was problematic ($\tau_b = -0.018, p = 0.900$). Therefore Hypothesis 5.2 was not supported as a negative correlation was not found between how much the male partner agreed that his partner’s drinking was problematic and his reported alcohol consumption.

**Table 22 — Kendall’s rank correlation matrix for the independent variables with continuous data.**

<table>
<thead>
<tr>
<th></th>
<th>Duration of problem</th>
<th>Rating of the extent of the problem</th>
<th>How much drunk in a typical week</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration of problem</strong></td>
<td>$\tau_b = 1.000$</td>
<td>$\tau_b = 0.142$</td>
<td>$\tau_b = 0.062$</td>
</tr>
<tr>
<td></td>
<td>$p = 0.313$</td>
<td></td>
<td>$p = 0.659$</td>
</tr>
<tr>
<td><strong>Rating of the extent of</strong></td>
<td>$\tau_b = 0.142$</td>
<td>$\tau_b = 1.000$</td>
<td>$\tau_b = -0.018$</td>
</tr>
<tr>
<td><strong>the problem</strong></td>
<td>$p = 0.313$</td>
<td></td>
<td>$p = 0.900$</td>
</tr>
<tr>
<td><strong>How much drunk in a</strong></td>
<td>$\tau_b = 0.062$</td>
<td>$\tau_b = -0.018$</td>
<td>$\tau_b = 1.000$</td>
</tr>
<tr>
<td><strong>typical week</strong></td>
<td>$p = 0.659$</td>
<td></td>
<td>$p = 0.900$</td>
</tr>
</tbody>
</table>

**Length of female partners’ drinking problem**

_Hypothesis 6.1: Where male partners reported that the duration of the female’s drinking problem was longer, they would report using more tolerant and inactive coping behaviours._
Hypothesis 6.2: Where male partners reported that the duration of the female's drinking problem was longer, they would report using more withdrawal coping behaviours.

Descriptive analysis

Male partners were asked how long (in years and months) their female partner's drinking had been problematic (Appendix C). One male did not complete this section of the questionnaire. A second responded with a 0, indicating that he did not feel that his partner's drinking was problematic. The remaining 26 reported that their partner's drinking had been problematic for a mean of 7.55 years (90.58 months, range 18 to 240 months, SD=62.04).

Correlational analysis

Hypotheses 6.1 and 6.2 stated that the male partners would use more tolerant and more withdrawal coping behaviours the longer the female's drinking had been problematic. Table 23 shows the correlational analysis for the duration of the females' drinking problem and the Coping Questionnaire scores.

There were significant positive correlations between how long the male partners felt their female partner's drinking had been problematic and the total coping score ($r_b = 0.355, p=0.011$), the engaged coping score ($r_b = 0.288, p=0.042$) and the tolerant coping score ($r_b = 0.374, p=0.009$). This suggests that the longer the drinking had been a problem, the more frequently the male partner reported using tolerant and engaged coping behaviours. This supports Hypothesis 6.1, but Hypothesis 6.2 is not supported.
as male partners were not found to report using more withdrawal coping behaviours the longer the drinking had been problematic.

**Table 23 — Kendall’s rank correlations for the duration of the females’ drinking problem and the Coping Questionnaire scores.**

<table>
<thead>
<tr>
<th>Total coping score</th>
<th>Engaged coping score</th>
<th>Tolerant coping score</th>
<th>Withdrawal coping score</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \tau_b = 0.355^* )</td>
<td>( \tau_b = 0.288^* )</td>
<td>( \tau_b = 0.374^{**} )</td>
<td>( \tau_b = 0.203 )</td>
</tr>
<tr>
<td>( p = 0.011 )</td>
<td>( p = 0.042 )</td>
<td>( p = 0.009 )</td>
<td>( p = 0.152 )</td>
</tr>
</tbody>
</table>

\(^*p < 0.05\) (two-tailed test)

\(^{**}p < 0.01\) (two-tailed test)

**Regression analyses**

A regression analysis was carried out to see if the independent variables predicted any of the variance of the dependent variable; the scores on the Coping Questionnaire. The independent variables used in a regression analysis need to be of at least interval data (Field, 2001), therefore the scores of the Causal Dimensions Scale were excluded as they provided ordinal data. The following independent variables were entered into the regression analysis: the extent to which the male agreed that his female partner’s drinking was problematic; the duration of the female’s drinking problem; and the amount the male reported drinking in a typical week.

There were no significant correlations between the independent variables as shown in Table 22, therefore a forced entry model of regression was used, as opposed to a stepwise model (Clark-Carter, 1997). A separate regression analysis was carried out
for the total coping score and the three coping subscales, and the three independent variables were entered into the model separately.

The residuals from the regression analyses looking at the engaged coping subscale and the withdrawal coping subscale were not normally distributed (see Appendix U) therefore these analyses did not meet the assumptions for a regression analysis, were invalid and are not reported. Appendix U gives details of how the assumptions of the regression analyses were met for the total coping and the tolerant coping scores.

**Predictors of the total coping score**

Table 24 shows the results for the regression analysis looking at the predictors of the total coping score.

The extent to which the male partners agreed that their partner’s drinking was problematic was the best predictor and explained 30.1% of the variance of the total coping score. The duration of the drinking problem explained a further 7.0% and how much the male partner’s drank in a typical week explained a further 4.8%. In total, the model suggested that 41.9% of the variance of the total coping score could be explained by the three independent variables. The adjusted R² value suggests that if the model were generated from the population rather than this sample, these three variables would account for about 7.6% less variance (Field, 2001).

The F-ratio and significance levels show that the extent to which the male partners agree that their partner’s drinking is problematic significantly predicts the total coping score (F=10.790, p=0.003) and is a better predictor than when the duration of the
drinking problem and the male’s own alcohol consumption are added to the model
\( (p > 0.003 \text{ for the second and third models}) \).

**Table 24 – Results from the regression analysis looking at the predictors of the total
coping score.**

<table>
<thead>
<tr>
<th>Model</th>
<th>Predictors</th>
<th>R (independent variables)</th>
<th>R Square</th>
<th>R Adjusted</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Extent</td>
<td>0.549</td>
<td>0.301</td>
<td>0.274</td>
<td>10.790</td>
<td>0.003</td>
</tr>
<tr>
<td>2</td>
<td>Extent + duration</td>
<td>0.609</td>
<td>0.371</td>
<td>0.319</td>
<td>7.083</td>
<td>0.004</td>
</tr>
<tr>
<td>3</td>
<td>Extent + duration + alcohol consumption</td>
<td>0.647</td>
<td>0.419</td>
<td>0.343</td>
<td>5.523</td>
<td>0.005</td>
</tr>
</tbody>
</table>

Where 'extent' = the male partner's perception of the drinking problem on a scale of 1 to 10, 'duration' = how long the drinking had been problematic in months and 'alcohol consumption' = the male partners' alcohol consumption in units of alcohol.

The regression equation arising from this analysis was:

**Total coping score = (5.436 x extent) - 2.488**

The regression equation shows that the total coping score can be predicted by
multiplying the extent to which the male agrees that his partner has a drinking
problem by 5.436 and subtracting the constant value of 2.488.
Predictors of the tolerant coping subscale score

Table 25 shows the results for the regression analysis looking at the predictors of the tolerant coping subscale score. The extent to which the male partners agreed that their partner’s drinking was problematic was the best predictor of the tolerant coping score and explained 30.8% of the variance of the tolerant coping score. The duration of the drinking problem explained a further 7.3% and how much the male partner’s drank in a typical week explained a further 9.1%. In total, the model suggests that 47.2% of the variance of the tolerant coping score could explained by the three independent variables. The adjusted $R^2$ value suggests that if the model were generated from the population rather than this sample, these three variables would account for about 6.8% less variance (Field, 2001).

The F-ratio and significance levels suggest that the model that best predicts the tolerant coping score is the third, which includes all three independent variables ($F=6.864, p=0.002$). The regression equation arising from this analysis was:

$$
\text{Tolerant coping score} = (1.526 \times \text{extent}) + (0.024 \times \text{duration})
- (0.147 \times \text{alcohol consumption}) + 0.141
$$

This regression equation shows that that the tolerant coping score can be predicted by multiplying the extent to which the male agrees that his partner has a drinking problem by 1.526, multiplying the duration of the female’s drinking problem by 0.024 and adding these two together with the constant value of 0.141 and subtracting the value gained by multiplying the male’s own alcohol consumption by 0.147.
Table 25 — Results from the regression analysis looking at the predictors of the total coping score.

<table>
<thead>
<tr>
<th>Model</th>
<th>Predictors (independent variables)</th>
<th>R</th>
<th>R Square</th>
<th>Adjusted R Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Extent</td>
<td>0.555</td>
<td>0.308</td>
<td>0.280</td>
<td>11.114</td>
<td>0.003</td>
</tr>
<tr>
<td>2</td>
<td>Extent + duration</td>
<td>0.617</td>
<td>0.381</td>
<td>0.329</td>
<td>7.382</td>
<td>0.003</td>
</tr>
<tr>
<td>3</td>
<td>Extent + duration + alcohol</td>
<td>0.687</td>
<td>0.472</td>
<td>0.404</td>
<td>6.864</td>
<td>0.002</td>
</tr>
</tbody>
</table>

Where 'extent' = the male partner's perception of the drinking problem on a scale of 1 to 10, 'duration' = how long the drinking had been problematic in months and 'alcohol consumption' = the male partners' alcohol consumption in units of alcohol.

The similarities in the results between the two regression analyses can be explained by the significant positive correlation between the total coping and the tolerant scores ($r_b = 0.699, p = 0.000$), see Table 21 above.

Coping strategies

Descriptive analysis

Male partners were asked if they had done any of a range of things to help them cope with their female partner’s drinking (Appendix C). All 28 male partners completed this section of the questionnaire and Table 26 shows their responses. Nearly three
quarters of the male partners said they had talked to family or friends to help them cope with their partner’s drinking, and nearly a third had sought professional help for themselves. Half of those who smoked cigarettes and cigars said they had smoked more than usual and a third of those who drank alcohol said they had drunk more than usual whilst trying to cope. A quarter had used exercise to help them cope.

One male responded that he had done all of the things that were mentioned: talked to friends, used exercise, sought help from a professional, smoked more and drunk more than usual. This male partner had a total coping score of 69, which was the highest of all the male partners. Two male partners reported that they had used none of the things listed to help them cope, and these male partners had total coping scores of 2 and 7 respectively, which were the two lowest total coping scores of all the male partners.

Table 26 – Numbers and percentages of the male partners who had used a range of coping strategies.

<table>
<thead>
<tr>
<th>Coping strategy</th>
<th>Number (%) of male partners who said they had used the coping strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=28</td>
<td></td>
</tr>
<tr>
<td>Talked to family or friends</td>
<td>20 (71.4)</td>
</tr>
<tr>
<td>Sought professional help for themselves</td>
<td>9 (32.1)</td>
</tr>
<tr>
<td>Drunk more than usual</td>
<td>8 (32% of those who drank)</td>
</tr>
<tr>
<td>Smoked more than usual</td>
<td>8 (53.3% of those who smoked)</td>
</tr>
<tr>
<td>Used exercise</td>
<td>7 (25.0)</td>
</tr>
</tbody>
</table>
Male partners’ involvement in treatment

Descriptive analysis

Male partners were asked about their involvement in their female partner’s treatment (Appendix C). Nineteen (67.9%) of the male partners said that they had been involved in their partner’s treatment. Of the nine (32.1%) who reported that they had not been involved, six (66.7%) said they would have liked to have been involved and only three (33.3%) said that they would not have wanted to have been involved.

Of the three who said that they would not have liked to have been involved in their partner’s treatment, reasons given were; that she ‘would not welcome the intrusion’, that he ‘let her get on with it’ and that work prevented him from being involved.
Coping Questionnaire

The scores from the Coping Questionnaire (Orford, 1996, Appendix A) show that the male partners in the current study were engaging in behaviours to help them cope with the problem drinking of their female partner. The fact that all male partners reported using at least some of the behaviours on the Coping Questionnaire, and taking the process model of stress and coping into consideration (Folkman & Lazarus, 1984), suggests that they saw their female partner’s drinking as problematic at some level and were therefore coping with a source of stress. As found in other studies (Orford et al., 1992; Velleman et al., 1993) all male partners reported using more than one type of coping strategy, which gives rise to discussion about coping as a fixed personality characteristic (Lazarus & Folkman, 1984).

Orford et al. (1975) found that a high frequency of wives’ coping behaviours was related to a poor outcome for the husband’s problem drinking and concluded that a more frequent use of coping behaviours reflected a situation where there was more with which to cope. The current study found a high frequency of coping behaviours in the sample of male partners and in some cases, higher than in the comparison sample of female partners (Orford et al., 1998). Although further research would be needed to confirm this, if the finding from Orford et al. (1975) is generalisable across genders, then the prognosis for the female problem drinkers is not encouraging.
Engaged coping

In terms of the three different ways of coping presented by Orford et al. (1998), the item mean scores for the different subscales showed that the male partners reported using engaged coping behaviours (those behaviours that are aimed at changing the drinker) most frequently. This was supported by the comments that the male partners made. They were invited to add any other things that they had done because of their female partner's problem drinking at the end of the Coping Questionnaire. The majority of these comments were seen by the author as related to the engaged way of coping (see Appendix O).

When compared to the sample of female partners in the Orford et al. (1998) study, the highest engaged coping scores were from male partners in the current study, indicating that in some cases they reported using a higher frequency of coping behaviours than their female counterparts. Orford et al. (1975) concluded that wives did more engaged coping when there was more to cope with, which suggests that some of the female problem drinkers in the current study were presenting more problems for their male partners than the male problem drinkers were for the female partners in the Orford et al. (1998) sample. This challenges the idea that female family members are more affected by a partner’s problem drinking (Yates, 1988). Rychtarik (1990) stated that frequency measures of coping behaviours reflect the severity of the drinking. Although no data on the female’s alcohol consumption or drinking behaviours was collected in the current study, it has been suggested that high levels of coping behaviours relate to a high level or frequency of alcohol consumption and/or problematic behaviours (Rychtarik, 1990; Rychtarik et al., 1988). Given the reported
reluctance of female problem drinkers to present to services (Thom, 1986; Thom & Green, 1996), this then could reflect a highly complex group of problem drinkers.

The mean total coping and engaged coping subscale scores of the male partners in the current study were comparable to those of the female partners in the Orford et al. (1998) study, but there was a greater spread of scores amongst the male partner scores which showed they responded more variably to each other than the female partners.

The high levels of engaged coping behaviours may relate to the fact that the sample in the current study was recruited through treatment services. Orford et al. (1998) suggested that engaged coping may be more functional if the drinker is contemplating change and it is assumed that the majority of those in contact with services wish to change their alcohol consumption in some way. High engagement may also reflect the fact that the male partners were concerned for the well-being of a loved one, which has been found to lead to fewer distancing and avoidant behaviours (Folkman et al., 1986).

Controlling behaviours are seen as part of the engaged coping subscale (Orford et al., 1998) and among the comments added at the end of the Coping Questionnaire were several that reflected the control element of engaged coping (see Appendix O). Raine (2001) talked of the ways that male partners may try to control a female’s drinking or drug use. She suggested that there was a continuum of control and that where mild levels of control failed to achieve the desired result, threatened or actual violence may be used. The shorter version of the Coping Questionnaire (Orford, 1996) was used in the current study and this does not contain questions related to aggressive ways of
trying to control a person’s substance use. Two of the male partners in the current study added comments which indicated they had resorted to aggressive behaviours whilst trying to cope with their female partner’s problem drinking.

Tolerant coping

The mean scores and standard deviations of the tolerant subscale of the Coping Questionnaire indicated that the male partners were generally using more tolerant coping behaviours than the comparison group of female partners in the Orford et al. (1998) study. Tolerant coping behaviours were found to positively correlate with a measure of physical and psychological symptoms in the person trying to cope (Orford et al., 2001) which suggests this way of coping is not adaptive for family members. Therefore the high levels of tolerant coping behaviours seen in the sample in the current study suggest that the male partners may be suffering poor physical and psychological health.

Tolerant ways of coping are seen to include inactive behaviours and the sacrificing and accepting aspects of tolerance (Orford et al., 1998). It could be argued that these ways of responding to a problem drinker fit with the ‘disease’ model of problem drinking (Davies, 1997). When drinking is seen in terms of an illness or disease, the cause is seen as within the drinker and as being stable over time. The drinker is seen as not being able to help or change their drinking behaviour, and therefore those around the drinker are often sympathetic and caring towards them. They are more tolerant of the drinking behaviour as they believe the drinker is ill. One male partner commented that he attended Alcoholics Anonymous and a second that he attended Al-
Anon. Therefore it would be expected that these two male partners ascribed to the disease model of problem drinking.

If the high levels of tolerant behaviours were due to the male partners holding the disease model of problem drinking, associations would be expected between the attributions and the tolerant coping subscale. The Coping Questionnaire scores of the male partners who rated the cause of their partner's drinking as stable and uncontrollable (i.e. unchangeable and consonant with the disease model) were compared with those of the male partners who rated the cause as unstable and controllable (i.e. changeable). No significant differences were found between the two groups, suggesting that the disease model did not account for the use of tolerant coping behaviours. One reason why no difference was found may be the small numbers in each group. Only five and four male partners respectively made attributions which showed a clear pattern of unchangeable or changeable beliefs about the cause of the drinking. Larger groups may have revealed differences in the Coping Questionnaire scores of male partners making such attributions.

**Withdrawal coping**

The male partners in the current study were found to have significantly lower withdrawal coping behaviour scores than the female partners in the Orford et al. (1998) sample. This was contrary to what was expected and goes against the observation by Orford et al. (2001) that a sub-sample of husbands in their study had the highest withdrawal scores of all the English family members.
Being able to withdraw from the drinking behaviour has been seen as adaptive (Barber & Crisp, 1995; Gorman & Rooney, 1979) and it seems that the male partners in the current sample were less able to do this than the female partners in the Orford et al. (1998) sample. Withdrawal coping behaviours on the Coping Questionnaire include items which indicate avoidance of the drinking problem and an independence from the problem drinker. Holmila (1994) described the amount of stress caused by a problem drinker as a function of whoever saw the drinking a problematic and the amount of time that person spent in contact with the drinker. If a person is unable to withdraw from a problem drinker it is expected that they would be with the drinker more often and therefore may be more affected by the drinking behaviour.

High levels of disengagement that indicate that there is no bond between a problem drinker and their partner were found to relate to a poor prognosis (Orford et al., 1975). In the current study the male partners reported a high level of coping behaviours, which has also been linked to a poor outcome for the problem drinker (Orford et al.), but the fact that they report low levels of withdrawal behaviours and high levels of engaged behaviours suggests they are not disengaged from their partners. Therefore their coping behaviours may be linked to a positive prognosis for the female problem drinker. Further research is needed to explore the link between the male partners’ coping behaviours and the female partners’ treatment outcome.

**Predictors of coping behaviours**

The tolerant coping behaviour score was found to be predicted by a combination of three independent variables: the extent to which the male partner agreed that his female partner’s drinking was problematic; the length of time the female’s drinking
had been a problem; and the male partner's own alcohol consumption. Due to the high positive correlation between the engaged and the tolerant coping scores, it is suggested that these variable may also have predicted the engaged coping score (this analysis was not carried out as the data did not meet the necessary assumptions). It was not possible to carry out a regression analysis for the withdrawal coping scores.

**Gender differences in coping**

Comparison of the Coping Questionnaire scores of the male partners in the current study, the female partners in the Orford et al. (1998) study and the female partners in the Hurcom et al. (1999) study, showed that differences in the scores between the three groups were not restricted to gender. For example, the female partners in the Orford et al. study reported a lower frequency of using tolerant coping behaviours than the male partners in the current study, and the female partners in the Hurcom et al. (1999) study reported a higher frequency of tolerant behaviours than the male partners in the current study. This suggests that the observed differences may be due to some other factor than gender.

**Age**

The sample of female problem drinkers and male partners in the current study were found to be older than those in the comparison group (Orford et al., 1998). The ages of the male partners in the current study were concentrated in the 45 to 54 years age range and showed less variance than those in the Orford sample. It has been found that younger alcoholic women report more family and social rejection than older women (Gomberg, 1988). Therefore the male partners of younger female problem drinkers may have been less willing to participate in the current study leading to a
sample of older male partners. Gomberg (1988) suggested that the rejection of younger female drinkers is due to the more visible nature of younger women's drinking and it is suggested that older cohorts of women have been strongly socialised to avoid open alcohol use and public intoxication (Brennan et al., 1993), which means their drinking behaviours are more tolerated. Therefore the older ages seen in the current sample of male partners, and the high level of engaged behaviours they reported, may reflect a greater tolerance due to the nature of the drinking behaviours of older females.

**Relationship status**

A high number of the females on the caseloads of the clinicians in the NHS services were excluded on the grounds that the clinician felt that it would not be appropriate to approach them about the study due to relationship problems between the female and her male partner. If it had been possible to approach those males where there were relationship difficulties, a group of male partners may have emerged who used less tolerant and more withdrawal coping behaviours, than those in the current sample. It may be that the sample of husbands reported to have high withdrawal coping scores in the Orford et al. (2001) study included some who were experiencing relationship difficulties. It would have been interesting to compare the male partners in the current study with this sample of husbands on such factors.

It could be argued that leaving a relationship is the ultimate use of withdrawal coping behaviours. In reflecting on the small numbers of men who attended Al-Anon (a self-help group for family members affected by alcohol problems run along similar lines to Alcoholics Anonymous), Ablon (1974), as cited in Wilson (1980), suggested that
male partners were more likely to leave a marriage if the female drinks than vice versa. A higher rate of separation and divorce has been reported among female problem drinkers when compared with male problem drinkers (McCrady, 1990) and Alcohol Concern (2002) have gone as far as to suggest that nine in ten women stay with alcohol dependent men whereas only one in ten men stay with alcohol dependent women. What is not clear from these studies is whether the drinking behaviour leads to marital problems or whether the drinking is a reaction to the relationship difficulties. Some studies imply the former (Pérodeau, 1994), but Waterson (2000) described women who drank to block out the emotions during and following a break-up.

The fact that there seem to be a high number of relationship break-ups when the female is a problem drinker, then leads to questions about those relationships that do not break up. In looking at the influence of marriage on the treatment of male problem-drinkers, Orford et al. (1976) found that those with a cohesive marriage were significantly more likely to have a good treatment outcome. A cohesive marriage was seen as one containing mutual affection, where the husband was involved in family tasks and where there was optimism for the future of the marriage. It could be that the male partners in the relationships that do not break up cope in different ways to those male partners who are involved in relationships that do break up. For example, it could be suggested that male partners who stay in relationships with female problem drinkers are more committed to the relationship, which could express itself in higher engaged and more tolerant behaviours, and that those who leave are more likely to use withdrawal coping behaviours. The male partners in the current study may reflect the former group.
Validity of the three factor structure

There are some questions over the validity of the three coping factors presented by Orford et al. (1998). The male partners were invited to add extra comments at the end of the Coping Questionnaire and these were rated by the author according to which of the three ways of coping they were seen to relate to. A large number of the comments were about engaged behaviours, but more specifically were seen to reflect some aspect of control. Conceptualising coping in terms of three factors may be too narrow and means that valuable detail is inevitably lost.

In the added comments at the end of the Coping Questionnaire, one male partner wrote that he had originally felt “in the depths of despair” but had come to see his partner’s drinking as an “illness” (see Appendix O). The Coping Questionnaire focuses on behavioural coping and therefore does not include cognitive coping strategies such as those described by Lazarus and Folkman (1984) in their category of emotion-focused coping. Therefore it does not reflect the full repertoire of possible coping strategies.

J. Orford (personal communication, May 12, 2003) suggested that the engaged and withdrawal subscales of the Coping Questionnaire may each contain two separate factors: the engaged subscale being made up of emotional controlling behaviours and of assertive behaviours; and the withdrawal subscale being made up of avoidant behaviours and independent behaviours. Considering coping behaviours in this way may provide more information and an explanation as to why there were differences in the samples reported in the current study.
A further analysis of the data suggested that for this sample of male partners, some items on the Coping Questionnaire did not relate to the subscale to which they contributed in the scoring. For example, this analysis suggested that the first question, which is seen as part of the engaged subscale, had a stronger relationship with the items on the withdrawal subscale. This suggests that a principal component or factor analysis of the Coping Questionnaire data for a larger sample of male partners of female problem drinkers may reveal a different structure than the three factors presented by Orford et al. (1998).

The first question on the Coping Questionnaire asks family members if they have ever refused to lend money to their substance using relative. Interestingly, Mulford (1977) reported that fewer female problem drinkers reported that their spouse had complained about the amount of money they spent on alcohol, compared with male problem drinkers, suggesting that there may be gender differences in the responses to this question.

**Casual Dimensions Scale**

*Causes and reasons for drinking*

When completing the Causal Dimensions Scale (Appendix B), the male partners gave what they saw as the main reason or cause for their female partner's problematic drinking (see Appendix R). The responses given supported the finding that women are likely to start drinking heavily after a specific life event, or as a way of coping with daily stressors (Allan & Cooke, 1985; Thom, 1997). A large number of males in the current study reported that their female partner drank due to being depressed (n=8)
and four male partners gave reasons that indicated their partner’s drinking was linked to incidents that had happened in her past or her childhood. This supports the finding that substance abuse is strongly related to intra-psychic problems among women (Robbins, 1989).

Wilsnack and Cheloha (1987) reporting on data from an American population study, stated that females were more likely to report problem drinking indicators if they had lost a role or role relationship. This appeared to be true in at least one case in this study, where the male partner indicated that his wife drank due to the fact that their son had left home, suggesting she had lost an active part of her mother role. There was also a high rate of unemployment amongst the female problem drinkers; 35.7% of the female problem drinkers in the current study were reported to be unemployed. These women could be seen as lacking a particular working role.

A large number of the male partners referred to depression and low self-esteem or self-confidence in the reasons as to why their female partner drank. This supports the assertion of Raine (2001) that other people are likely to attribute drinking problems to more socially acceptable causes such as depression or anxiety. Although in general the male partners were able to state a reason or cause for their partner’s drinking, the cause and effect is unclear. For example, it is not clear whether depression leads to problem drinking or vice versa.

Male partners gave what they saw as the main cause or reason for their female partner’s problem drinking. It may be that there were other more pertinent or salient causes that the male partners did not mention.
Causal attributions

As expected the male partners made a high number of attributions that the cause of the female’s problem drinking was internal to her, which is seen to reflect the actor-observer difference (Munton et al., 1999). As mentioned previously, no significant correlation was found between those male partners who made attributions that the cause of their female partner’s drinking was unchangeable and the tolerant coping scores. This would have been expected if the male partners held views about their partner’s drinking that were consonant with the disease model of drinking.

No significant correlations were found between the causal dimensions and the engaged and withdrawal coping scores. The fact that no correlations were found questions whether attributions about the cause of the female’s drinking have a role in the coping process (see Figure 2), but there are some methodological considerations which need to be taken into account.

Methodological considerations

Demand characteristics are seen as having an impact on the reliability and validity of the information sought (Babor, Stephens & Marlatt, 1987) and there are some questions as to both the reliability and the validity of the Causal Dimensions Scale.

Reliability

Three of the male partners responded to this measure in a manner that suggested that they had not fully understood the way it was intended to be completed. Therefore this raised questions as to whether other male partners had fully understood this measure thereby affecting the reliability of the results. Although there was no indication from
the pilot study that this would be the case, it seemed that the use of numbers on the Likert scale (see Appendix B) had been confusing and the use of non-numbered points may have been less ambiguous. Kellett (2002) found that the Causal Dimensions Scale was difficult for people to understand and that they needed some help to complete this measure. If it had been feasible to interview participants as in the study carried out by Kellett (2002), this potential source of error may have been avoided.

*Validity*

Further analysis of the data from the Causal Dimensions Scale questioned the validity of the three dimensions. Each dimension had three questions, but from the data gathered in the current study, the three questions were not found to correlate with each other, which is what would be expected if they were all measuring the same dimension (Clark-Carter, 1997). This would have been confounded by the errors made if some male participants had not completed the measure as it was intended.

When completing the Causal Dimensions Scale (Appendix B) male partners were asked to give what they thought was the main reason or cause that their female partner drank, and to rate this along several dimensions. This meant that male partners were rating the cause or reason that the female drank, rather than the drinking itself. Many of the male partners felt that their female partner drank due to depression. It would be possible for him to believe that the depression that caused the drinking was stable and uncontrollable, but also to feel that the female could control and change her drinking behaviours. Therefore it seems that there was a conceptual error in the thought that the Causal Dimensions Scale would provide information on the male partner’s attributions about the female partner’s drinking behaviour.
The Causal Dimensions Scale made use of Likert scales to rate the attributional dimensions (see Appendix B). Male partners who gained similar scores were grouped together, but Clark-Carter (1997) cautions against using such an approach as two people may gain the same score, but may have different patterns of responding, so any similarities between them cannot be assumed.

The above observations then question the assumption that the Causal Dimensions Scale could be used to provide information on the secondary appraisal in the process model of stress and coping (Lazarus & Folkman, 1984, see Figure 2). If the responses on the Causal Dimensions Scale do not fit into the secondary appraisal process, then this could explain why no relationships were found with the Coping Questionnaire scores.

**Male partners’ alcohol consumption**

Unlike what was expected, there were few heavy drinking male partners in the sample in the current study. But the male partners’ alcohol consumption did reflect that found in a general population study carried out in Britain (Lader & Meltzer, 2002). In terms of abstinence, 10.7% of the current sample reported that they did not drink, which compared with 12% of those in the general population study (Lader & Meltzer). As a group, the male partners in the current study who drank alcohol, reported that they drank an average of 16.44 units of alcohol in a typical week. Again, this compared with the results of the general population study that found men drank a mean of 16.2 units a week (Lader & Meltzer).
One male partner in the current study reported drinking 46 units of alcohol in a typical week and this was seen as an outlying data point. When this was removed from the analysis, the remaining male partners (n=24) reported drinking a mean of 13.52 units of alcohol, which is lower than that found in the general population study cited above.

The male partners in the current study were an older group, and it has been found that alcohol consumption decreases as people get older. Lader and Meltzer (2002) found that among men, the number who reported drinking more than four units of alcohol on one day in the previous week, dropped from 58% of 25 to 44 years olds, to 28% of those over 65.

Some exclusions were made due to the male partner being in contact with a treatment service for his own substance use problem. The rationale behind this was that it would be difficult to say if the female was coping with the male’s problem drinking or vice versa. This decision seemed to be justified as a third of the male partners who drank reported that they themselves had drunk more alcohol than usual whilst trying to cope with their female partner’s problem drinking. The exclusion of the male partners who were in contact with services due to their own drinking problems assumes that if someone is not receiving treatment, their drinking is not problematic, which is unlikely to always be the case. Six exclusions were made due to the male partner being in contact with alcohol services in his own right. If these six male partners had been included, depending on where they were in terms of controlling their alcohol intake, there might have been a higher number of heavy drinking male partners in the sample in the current study.
The alcohol consumption of the male partners was divided into three categories: abstinent; light drinkers; and heavy drinkers. The majority of the male partners were classed as light drinkers and the unequal group numbers meant that not all the planned analyses could be carried out.

A significant difference in the total and tolerant Coping Questionnaire scores was found between those classed as abstinent and those classed as heavy drinkers, but caution needs to be taken when interpreting this finding, as it was based on very small numbers (three and four respectively) and this finding may not be replicated in a larger sample.

The male partners who reported being abstinent also reported more frequent use of all coping behaviours and of tolerant coping behaviours in particular (this finding would be expected due to the strong positive correlation between the total and tolerant coping scores). It was expected that the male partners classed as heavy drinkers would be more tolerant of the female partner's drinking, but this confuses tolerant coping with tolerance of drinking. It may be that if a male partner is tolerant of his partner's drinking, then he is less likely to see it as a problem and therefore will not use any form of coping behaviour. If this were the case, heavy drinkers would be less likely to see female's drinking as problematic. But this was not found to be the case in the current study.

Male partners were asked if they felt they had ever drunk more than usual in an attempt to cope with their female partner's problem drinking, and nearly a third of those who drank reported that they had. Therefore drinking was seen as a way of
coping by a large number of the male partners. In terms of the process model of stress and coping (Lazarus & Folkman, 1984) it was hypothesised that the male’s alcohol consumption would have an influence on the primary appraisal process (see Figure 2). The male’s alcohol consumption was found not to relate to how problematic the female’s drinking was seen, and a third of the male partner’s reported using alcohol as a coping behaviour. Therefore it seems that the male partners’ own alcohol use may play a bigger role at the coping behaviour stage rather than at the primary appraisal stage.

Although this information was not sought, one male partner who reported being abstinent commented that he used to be a heavy drinker and now attended Alcoholics Anonymous. It could be imagined that this male partner would be tolerant of his female partner’s problem drinking as he himself previously had had a problem and his attendance at Alcoholics Anonymous suggested he believed in the disease model of drinking. A further two male partners (both classed as light drinkers) indicated that they now drank less than they had previously. It is difficult to know whether this reduction in alcohol intake was related to drinking-related problems, whether they were trying to be good role models for their female partners or whether there had been a change in their circumstances (e.g. a reduction in drinking has been related to gaining employment (Marshall, 1996)). Raine (2001) suggested that there was little incentive for female problem drinkers to stop drinking if their male partners continued to drink heavily. In the case of these three male partners, there was evidence that they had cut down their own drinking and would be supportive of their female partner’s attempts to do the same.
Reliability of reported alcohol consumption

Unlike what was expected, few of the male partners of the female problem drinkers were heavy drinkers. It is unclear whether the male partners in the current study gave an accurate picture of their drinking. If they under-reported their alcohol consumption there are several possible reasons for this. Del Boca and Noll (2000) stated that errors may occur in data due to the complexity of a question and felt that asking someone to report on ‘typical’ or ‘usual’ patterns of behaviour was a difficult task. Therefore males may have found the question asking about their own typical drinking (see Appendix C) difficult to respond to and this may have led to an under-reporting of alcohol consumption.

It could also be argued that due to the close connection between the research and the treatment services, the male partners may have been reluctant to disclose an accurate picture of what they drank. This under-reporting may have been due to fears about being asked to engage with the service themselves. This was despite there being clear information about the confidentiality and anonymity associated with the study (see Appendices F and I), which is seen as enhancing the reliability of alcohol consumption measures (Carroll, 1995).

Another reason why male partners may have under-reported their alcohol consumption could be due to factors relating to social desirability (Babor et al. 1987). Carroll (1995) talked of the perceived positive and negative consequences of reporting substance use and this reason may have meant that those who had a higher level of alcohol consumption were reluctant to participate in the study. These factors may have been exacerbated by the example given in the instructions for the drinking diary.
Male partners may have felt that they could not report alcohol consumption that was greater than that of the given example.

It may have been that the self-selected sample who responded and participated in the study did accurately report their alcohol consumption and that those who drank more did not complete the questionnaire, or were those who were excluded from the study due to relationship difficulties or engagement in treatment services for their own drink-related problems.

**Perception of female partners’ drinking**

The majority of the male partners in the current study strongly agreed that their female partner’s drinking was problematic. This may have been due to the negative social and cultural views of female drinking which were discussed earlier (e.g. Forth-Finegan, 1991; Plant, 1997, Thom, 1997). In the process model of stress and coping (Folkman & Lazarus, 1984), socio-ecological factors are seen to influence several stages of the process (see Figure 1) and this would include these social and cultural influences. In the current study, on a number of occasions where the female problem drinkers did not give consent to participate, the clinician commented that the female did not want her partner to know the extent of her drinking or that he did not know she was receiving help from a treatment agency. This supports the idea that female problem drinkers fear a negative reaction from others and try to conceal their drinking (Raine, 2001). During the pilot and main phases of the study, the author met with four male partners of female problem drinkers. These male partners talked about the embarrassment their situations engendered. This supports the ideas of Kagle (1987)
and Wilson (1980) and suggests that the social and cultural factors may be particularly pertinent to how male partners cope, and would warrant further investigation.

No correlation was found between the male partner’s alcohol consumption and the extent to which he agreed that his female partner’s drinking was problematic. This suggests that the male partner’s own alcohol consumption did not influence whether he saw his partner’s drinking as problematic. It may be that male partners felt that agreeing with this statement was the most appropriate response as the female was currently in contact with a treatment service and this may have been reinforced by the fact that the current study was carried out through those treatment services.

The majority of the male partners strongly agreed that their female partner’s drinking was problematic. One male partner reported low agreement and his response stood out as an extreme data point. On the question asking about the duration of the female’s problem drinking this male partner put a 0, indicating that he did not feel his partner’s drinking was problematic. It could be argued that as the research was carried out through treatment services, the male partners felt that agreeing that the drinking was problematic was the most appropriate response.

It may be that those male partners who did not feel that their partner’s drinking was problematic were discouraged from participating, as drinking was couched in negative terms throughout the questionnaire pack. Throughout it was implied that the drinking caused problems and male partners who did not hold this view would not have valued the questionnaire and therefore may not have been motivated to respond. The research was carried out through treatment services which would have reinforced this idea.
A significant positive correlation was found between the perception of the female partner’s drinking and the tolerant and total coping scores on the Coping Questionnaire. The more that the male partner agreed that his female partner’s drinking was problematic, the more tolerant coping behaviours he reported using. This reflects the statement from Orford et al. (1975) that the more they have to cope with, the more coping behaviours someone uses. It may also reflect the fact that male partners held views related to the disease model of drinking, but, as mentioned previously, no correlations were found between the Causal Dimensions Scale and the Coping Questionnaire scores.

**Length of female partners’ drinking problem**

The male partners had been coping for a long period of time as it was reported that they felt their partner’s drinking had been problematic for a mean of 7.55 years (range 18 months to 20 years). Demographic information from one of the NHS services for all the females referred during the year between April 2002 and March 2003 showed that the average length of the problem drinking was 6.7 years (range 1 to 30 years) at assessment, which is similar to that of the sample in the current study. Although no information was collected on previous contacts with services, this finding seems to reflect the length of time it takes for female problem drinkers to seek professional help (Thom, 1987) It may be that this is exacerbated by families trying to conceal the female’s problem drinking due to the negative social attitude which accompanies female problem drinking, and feeling embarrassed by their inability to get her drinking under control.
As expected, a significant positive correlation was found between the length of the problem drinking and the tolerant coping scores on the Coping Questionnaire. The fact that the longer the female's drinking had been seen to be a problem, the higher the frequency of reported tolerant coping behaviours in the male partners is seen to relate to the effects of a prolonged stressor. Folkman and Lazarus (1984) talked about how the process of habituation would mean that a stressor would have less of an arousing effect if someone were exposed to it over a long period of time. In terms of coping with the problem drinking behaviour of a partner, this was seen to lead to a higher level of tolerant coping behaviours. This supports the idea that the duration of the drinking problem influences the process model of coping at the reappraisal stage (see Figure 2).

A significant positive correlation was also found between the length of the problem drinking and the engaged coping score. This is contrary to the suggestion that engaged coping may be more functional if the drinking problem has a short history (Hurcom et al., 1999; Orford et al., 1998), but may reflect the fact that the female problem drinkers were in contact with a treatment service, so the male partners may have been hopeful of a change in her drinking behaviour.

Converse to what was expected, no correlation was found between the length of the problem drinking and the withdrawal coping score. This relationship had been reported by Hurcom et al. (1999) in a sample of female partners of male problem drinkers, and it may be that this finding is gender specific. A higher level of withdrawal coping behaviours where the drinking had been problematic for longer would have been expected, as when coping fails to resolve the problem and the
stressor comes to be seen as unchangeable, there is a suggestion that people will use coping behaviours that distance them from the stress (Folkman et al., 1986). The fact that this relationship was not found in the current study could be explained by the fact that males tend to persevere with problem-focused coping (Folkman et al.), but it is not known over what time period this is the case.

Hurcom et al. (1999) reported a significant positive correlation between the duration of the female partner’s coping and the withdrawal coping score. But this difference may be due to the different phrasing of the question about the duration of the problem. It appears that in the Hurcom et al. study, female partners were asked how long they had been coping with their male partner’s drinking problem. In the current study, male partners were asked how long the female’s drinking had been problematic. It would be possible for a male partner to respond that the female’s drinking had been problematic for 10 years, even if he had only known her for two years. There is some ambiguity in this question and the reported findings should be viewed cautiously.

The fact that Hurom et al. (1999) found a positive correlation between the duration of the drinking problems and the withdrawal coping scores, and that this relationship was not found in the current study may be explained by factors other than gender. In the Hurcom et al. study a third of the female partners were recruited through generic mental health services and community advertising, which may have led to different characteristics of this sample, not all of whose partners would have been in active treatment. Age and relationship status were mentioned earlier as possible factors that may influence the coping behaviours of partners, and it may be that these are relevant here.
Behind the points outlined above, is the assumption that withdrawal coping behaviours equate with withdrawal from the problem drinker. If a family member does not feel close to the problem drinker, the drinking behaviour would not affect them as much and they may not feel the need to do any coping. In terms of the process model of stress and coping (see Figure 1), the drinking would be appraised as 'irrelevant' rather than problematic and coping would not be necessary. This idea gains some support from the fact that the extent to which the drinking was seen as problematic was positively correlated with the total coping score. The more the drinking was seen as a problem, the more coping behaviours the male partners reported.

**Other coping strategies**

Beyond coping behaviours which are in direct response to the drinking behaviour, male partners were asked about other things that they had done to cope. Only two male partners reported that they had not done even one of the things listed. Therefore the majority were seen as feeling that they needed to use other coping strategies.

A third of the male partners reported that they had sought professional help for themselves whilst trying to cope with their female partner's problem drinking. Although not asked directly in this study, this suggested that at least a third of the male partner's wanted help for their own problems of coping. The challenge for specialist alcohol services would be how to provide this support. Service B ran a family support group, but only two male partners in the current study had attended this, despite information being routinely provided to family members. The reluctance of male partners to approach services for their own needs is also reflected in the fact
that Service C had a ‘third party’ worker, but had only one male partner of a female problem drinker on their caseload.

**Involvement in treatment**

Two thirds of the male partners said they had been involved in the treatment of their female partner’s problem drinking. Statistics from Service A showed that for all the females referred in the year between April 2002 and March 2003, in only 12.29% of cases was the female’s partner reported by the clinician to be involved in the contact with the service. This then raises questions as to how the male partners and the clinical workers construed ‘being involved’. It may be that male partners saw themselves as ‘involved’ if they asked their partner about her sessions, whereas clinicians may consider involvement as the male partner attending sessions with the female problem drinker and taking an active part in her care plan.

**Clinical implications for treatment services**

Some treatment approaches have been developed that aim to change the way family members cope so that they can be a positive influence on the treatment of the problem drinker (e.g. McCrady et al., 1986). Certain ways that family members cope when they have a relative who has a drinking problem are seen as reinforcing the drinking behaviour (Barber & Crisp, 1995). The way that a male partner copes may therefore make it difficult for a female to change her drinking behaviour, as he is inadvertently reinforcing her drinking even though he sees himself as supportive, tolerant and engaged. This may particularly be the case if he is a heavy drinker himself. Therefore it would be important to explicitly engage the male partner in the treatment process so
that he can be as supportive as possible of the behaviours that are incompatible with the problem drinking.

There are also reasons for engaging male partners in services due to their own needs. Tolerant coping behaviours have been found to correlate with measures of physical and psychological symptoms in family members (Orford et al., 2001). The male partners in the current study were found to report a more frequent use of tolerant coping behaviours than a sample of female partners (Orford et al., 1998). Therefore it could be suggested that they would score highly on similar measures of physical and psychological symptoms.

One way to engage male partners might be to invite them to sessions. One of the NHS services (Service B) through which participants were recruited ran a family support group and information was routinely given to clients to pass on to their partners and any other concerned family members. Interestingly, only two of the male partners recruited through this service had attended this group, indicating that male partners may be reluctant to seek such help from substance misuse services. It may also be that male partners are reluctant to join support groups (c.f. Sternbach, 2003) and may be more willing to receive help on a one-to-one basis. One of the male partners recruited through the non-statutory service was receiving one-to-one support for his own needs as an affected family member. This needs further investigation, perhaps through the use of qualitative interviews.

When asked about his involvement in his partner’s treatment, one male partner responded that he had not been involved due to work commitments. A high number
of the male partners were in full-time employment, which means that services would have to be flexible and consider offering appointments outside normal working hours. The fact that many of the male partners worked full-time was expected and was one reason why a postal questionnaire design was used in this study.

Although there is some contention as to whether a substance use problem constitutes a mental health problem, the Mental Health National Service Framework (Department of Health, 1999) placed great emphasis on the role of carers and stated that their needs should be met. There are questions over whether male partners would see themselves as carers of female problem drinkers, but the findings of the current study suggest they may have needs which are not being met by services. Therefore specialist alcohol services should be more active in assessing the needs of male partners of female problem drinkers.

The fact that the female partners’ drinking was reported to have been problematic for a mean of 7.55 years suggests that it may take a long time before females are referred to treatment services. It is acknowledged that there are barriers to female problem drinkers seeking help (Beckman & Amaro, 1986; Schober & Annis, 1996; Thom, 1986), and if male partners are to be engaged, female problem drinkers need to be in contact with services. Therefore services need to be aware of and improve how accessible and acceptable they are to female problem drinkers (Thom & Green, 1996).
Limitations of the current study

External validity of the current study

It is unclear whether the findings of the current study would generalise to all male partners of female problem drinkers, and it is acknowledged that care needs to be taken about such assumptions (Dennis, Perl, Huebner & McLellan, 2000).

For ethical reasons, exclusions were made by the clinicians where it was felt inappropriate to approach a couple about the study which led to a selection bias. Amongst the reasons for exclusion were relationship difficulties, or where either the female problem drinker or her male partner had serious physical or mental health problems. In these cases it may be expected that due to other sources of stress beyond the drinking, there would be more coping, which might display itself in terms of more intolerance of the drinker, disengagement or more aggressive controls.

The sample in the current study was self-selected and due to the research process and ethical considerations it was not possible to collect demographic information about those who chose not to participate or were excluded. Therefore it is not known whether those who responded represented a specific category of male partners.

The study focused on how male partners coped with having a problem drinking female partner. A small number of exclusions were made due to the female problem drinker having a female partner. If the study had been conducted over a greater time period and with a larger sample, it may have been possible to make interesting comparisons with this group.
If it had been possible to send questionnaires to all male partners of female problem drinkers in the treatment services, the external validity may have been improved. Another way of improving external validity is to introduce a control group (Clark-Carter, 1997). If the Coping Questionnaire (Orford, 1996) had been used with a sample of partners of non-problem drinkers it would be expected that they would not have engaged in the coping behaviours and would have therefore gained low coping scores.

A high incidence of mental health problems have been reported in female problem drinkers (Robbins, 1989) and it may be that male partners of females with mental health problems such as depression, show similar types of coping to the male partners of female problem drinkers. It would not be appropriate to use the Coping Questionnaire with this group due to its alcohol-specific nature, but it would be interesting to use another measure of coping and compare this group with male partners of female problem drinkers. High rates of depression and anxiety have been found in female problem drinkers and there are questions as to whether the depression and anxiety would be a cause of stress for male partners regardless of the drinking behaviours. Therefore depression and anxiety could be seen as confounding factors in the process model of stress and coping (see Figure 1).

**Representativeness of female problem drinkers**

There was some evidence that the female problem drinkers in the current study were representative of those seen in one of the NHS services. Their drinking was seen as having been problematic for a comparable length of time and there were similarities in employment status, however they were seen as an older group. The sample in this
study was of females who had a male partner and it is unclear whether the females in the 45 to 54 years age range are more likely to be in a relationship, more likely to give their consent to participate or had male partners who were more likely to participate in a research study.

**Ethnicity**

Ethnic and cultural differences in attitudes to alcohol have been reported (Waterson, 1996) and it is suggested that they play a role in the process model of coping (Lazarus & Folkman, 1984). Although data on ethnic minorities was not collected as part of the demographic information in the current study, only small numbers were seen in the three treatment services. In Service A, 94.9% of the female drinkers seen in the year between 2002 and 2003 categorised themselves as White British. Therefore it is likely that the large majority of the sample in the current study were not from an ethnic minority. Therefore further research would be needed before findings could be generalised to couples from non-white backgrounds.

**Exclusions**

The male partners in the current study were self-selected and may not represent all male partners of female problem drinkers. Exclusions were made by the clinicians in the treatment services due to them feeling that it would not be appropriate to approach the couple due to current relationship difficulties. It may be that if these couples had been approached and had consented to participate, the male partners in these relationships may have reported a higher use of withdrawal coping behaviours. There is some evidence for this in the reported high number of separations of couples where the female is a problem drinker (Dahlgren, 1979).
One of the male partners reported being abstinent and indicated that he had previously drunk heavily. This male partner was not receiving help from the NHS or non-statutory alcohol services, but indicated that he attended Alcoholics Anonymous. One of the exclusion criteria was males who were known to be currently receiving help for their own alcohol problem through the treatment services. It would not have been possible to know if male partners were attending Alcoholics Anonymous prior to approaching them about the study, but this raises questions as to whether these male partners should also have been excluded, and whether the support provided by Alcoholics Anonymous should be classed as a form of treatment.

**Small sample size**

A high drop out and non-response rate led to a small sample size. It is assumed that a larger sample size would have allowed for the full range of comparisons between groups that were planned for the current study. For example, when looking at the male partner’s own alcohol consumption, there were only three males in the abstinent and four in the heavy drinking groups which meant that comparisons with the light drinking group were not valid. It would be expected that higher numbers would have led to a greater variance of scores and therefore the assumptions for the statistical analysis would have been met.

It was expected that there would be a high non-response rate and steps were taken to try to increase the return rate of the questionnaires. Those who did not return a questionnaire were sent a reminder letter and this led to a further eight questionnaires (28.6% of the total sample) being returned. Other factors to improve response rates of postal surveys that were used in this study included providing a freepost return
envelope, having a coloured questionnaire and compensating participants for their time (Fox, Crask & Kim, 1988; Yammarino, Skinner & Childers, 1991; Viljoen & Wolpert, 2002).

If there had been no exclusions in the current study, a larger sample would have been expected. Another way to gain a larger sample would have been to extend the data collection period, to devote more time to data collection and to have collected data from more sites. It was not possible to do this in the current study due to time constraints. Other ways to recruit male partners, such as through local media, could have been considered if the study had been conducted over a longer period of time.

**Confounding variables**

The common factor between all the male participants in the current study was that they had a female partner who had been referred to a NHS or non-statutory service for problems with alcohol consumption. Beyond this there may have been huge variations in circumstances and in the personal characteristics of the male partners and these were not considered in the current study.

Some of the factors that are seen as having an influence on the coping process were not considered in the current study and were seen as beyond the scope of this piece of research. For example, the non-drinking functioning of the problem drinker has been found to have an impact on a partner’s functioning (Finney et al., 1983). Other areas relevant to examine include the severity and chronicity of the female’s alcohol use and the physical and psychological functioning of both the female problem drinker and her male partner (Carroll, 1995).
The design of the current study was cross-sectional rather than longitudinal and the inclusion criterion was that the female was in contact with an alcohol treatment service. Therefore some females included in the study would have been in contact with services for some time. It is acknowledged that alcohol use can present a highly variable course that includes periods of abstinence and relapse (Carroll, 1995) and that coping behaviours vary with the intensity and frequency of drinking (James & Goldman, 1971). The process of coping is also seen to change over time due to changes in the environment and the appraisal process (Lazarus & Folkman, 1984).

There was no measure of the female problem drinker’s current alcohol use or of where she was in terms of the treatment process, and future research should include information of this kind in order to enable comparisons of different levels of consumption or different stages of treatment. Even with large sample sizes to allow such comparisons, it would be expected however that there would still be intra-group differences (Carroll, 1995).

Although there was no consideration of the female problem drinker’s current alcohol use, as the Coping Questionnaire measures the frequency of coping behaviours, it is seen as reflecting the severity of current drinking (Rychtarik, 1990; Rychtarik et al., 1988). Therefore, as the male partners in the current study all responded that they engaged in some coping behaviours, and that there was a wide range of coping scores, it could be suggested that the females were all engaging in drinking behaviours and that there was a range of these behaviours and of alcohol consumption.
Summary

The male partners in the current study were found to report using a range of coping behaviours and strategies in response to their female partner's drinking behaviours. It had previously been found that a group of husbands reported higher withdrawal coping scores than other family members (Orford et al., 2001), but this finding was not replicated in the current study. A comparison between the Coping Questionnaire scores of the male partners in the current study and a comparison group of female partners of male problem drinkers (Hurcom et al., 1999; Orford et al., 1998) showed that the male partners reported using a lower frequency of withdrawal coping behaviours. It is suggested that this finding is not only linked to gender, but that the older age and relationship status of the male partners in the current study may also be factors in this difference.

The male partner's own alcohol consumption, the length of the female's drinking problem and the extent to which the male partners saw the female's drinking as problematic were all found to be linked to the total Coping Questionnaire scores and in particular to predict the tolerant coping subscale scores.

A family member's coping behaviours have been found to have an impact on the treatment of problem drinkers (e.g. Orford et al., 1975) suggesting that services should be more active in trying to engage male partners in their female partner's treatment. The process model of stress and coping (Lazarus & Folkman, 1984) suggests that coping behaviours are used when something is perceived as stressful and that therefore male partners' experience of stress warrants further research.


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**Section B. Things You Do Because of Your Partner’s Drinking**

The questions are asking about what has happened in the last 3 months. For each question please tick the box that best applies to you. Please answer all questions.

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<thead>
<tr>
<th></th>
<th>No</th>
<th>Once or twice</th>
<th>Sometimes</th>
<th>Often</th>
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</thead>
<tbody>
<tr>
<td>1. Have you refused to lend your partner money or to help your partner out financially in other ways?</td>
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<td>2. Have you put the interests of other members of the family before your partner?</td>
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<td>3. Have you put yourself out for your partner, for example by getting her to bed or by clearing up mess after her when she has been drinking?</td>
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<td>4. Have you given your partner money, even when you thought it would be spent on drink?</td>
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<td>5. Have you sat down together with your partner and talked frankly about what could be done about her drinking?</td>
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<td>6. Have you started an argument with your partner about her drinking?</td>
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<td>7. Have you pleaded with your partner about her consumption of alcohol?</td>
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<td>8. When your partner was under the influence of drink, have you left her alone to look after herself or kept out of her way?</td>
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<td>9. Have you made it quite clear to your partner that her drinking was causing you upset and it had to change?</td>
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<td>10. Have you felt too frightened to do anything?</td>
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<td>11. Have you tried to limit your partner’s drinking by making some rule about it, for example forbidding drinking in the house or stopping your partner from bringing drinking friends home?</td>
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<td>12. Have you pursued your own interests or looked for new interests or occupation for yourself or got involved in a political, church, sports or other organisation?</td>
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<td>13. Have you encouraged your partner to take an oath not to drink?</td>
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<td>14. Have you felt too hopeless to do anything?</td>
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<td>15. Have you avoided your partner as much as possible because of her drinking?</td>
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<td>16</td>
<td>Have you got moody or emotional with your partner?</td>
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<td>17</td>
<td>Have you watched your partner's every move or checked up on your partner or kept a close eye on her?</td>
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<td>18</td>
<td>Have you got on with your own things or acted as if your partner wasn't there?</td>
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<td>19</td>
<td>Have you made it clear that you won't accept your partner's reasons for drinking, or covered up for her?</td>
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<td>20</td>
<td>Have you made threats that you didn't really mean to carry out?</td>
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<td>21</td>
<td>Have you made it clear to your partner your expectations of what she should do to contribute to the family?</td>
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<td>22</td>
<td>Have you stood up for your partner or stood by your partner when others were criticising her?</td>
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<td>23</td>
<td>Have you got in a state where you didn't or couldn't make a decision?</td>
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<td>24</td>
<td>Have you accepted the situation as a part of life that couldn't be changed?</td>
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<td>25</td>
<td>Have you accused your partner of not loving you or of letting you down?</td>
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<td>26</td>
<td>Have you sat down with your partner to help your partner sort out her financial situation?</td>
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<td>27</td>
<td>When things have happened as a result of her drinking, have you made excuses for your partner, covered up for your partner or taken the blame yourself?</td>
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<td>28</td>
<td>Have you searched for your partner's drink or hidden or disposed of it yourself?</td>
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<td>29</td>
<td>Have you sometimes put yourself first by looking after yourself or giving yourself treats?</td>
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<td>30</td>
<td>Have you tried to keep things looking normal, pretended all was well when it wasn't or hidden the extent of your partner's drinking?</td>
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</table>

Is there anything else you have done because of your partner's drinking?
### Section C. Why your partner drinks

People often believe there is a reason why other people drink too much. We are interested in your opinion about why your partner drinks.

What would you say is the **main** cause of your partner’s problem drinking?

---

Think about the cause (or reason) that you have written above. The items below concern how you feel about that cause.

Please read each question and circle one number to show how strongly you agree/disagree with the statements. Please answer all the questions.

1) **Is the cause:**

<table>
<thead>
<tr>
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<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<tbody>
<tr>
<td>Something about your</td>
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<td>Something about others</td>
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2) **Is the cause:**

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<td>Controllable</td>
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<td>by your partner or</td>
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<td>Uncontrollable</td>
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3) **Is the cause something that is:**

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<td>Permanent</td>
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<td>Temporary</td>
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4) **Is the cause something:**

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<td>Intended by your partner</td>
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<td>or other people</td>
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<tr>
<td>Unintended by your</td>
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<tr>
<td>partner or other people</td>
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</tbody>
</table>

5) **Is the cause something that is:**

<table>
<thead>
<tr>
<th></th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inside of your</td>
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<td></td>
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<td></td>
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<td>partner</td>
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<td></td>
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<td>Outside of your</td>
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<td>partner</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
6) Is the cause something that is:

<table>
<thead>
<tr>
<th>Stable over time</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

7) Is the cause something that:

<table>
<thead>
<tr>
<th>Reflects an aspect of your partner</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reflects an aspect of the situation</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

8) Is the cause something that is:

<table>
<thead>
<tr>
<th>Unchangeable</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Changeable</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

9) Is the cause something for which:

<table>
<thead>
<tr>
<th>Someone is responsible</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>No one is responsible</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>
**Section A. - About You**

Please tick a box next to the answer that best applies to you.

1. Your age:
   - Under 18
   - 18 to 24
   - 25 to 34
   - 35 to 44
   - 45 to 54
   - 55 to 64
   - 65 and over

2. Which of the following best describes you?
   - Employed/self-employed full-time
   - Employed/self-employed part-time
   - Unemployed
   - Full-time carer (e.g. to your children, or a dependent adult)
   - Retired

3. Your partner is being seen by someone from the alcohol team. To what extent do you agree that she has an alcohol problem?

   **Instructions**
   
   Mark the line to indicate how much you agree that your partner has an alcohol problem.
   
   For example, if you agree, but don't strongly agree, you would mark the line nearer the right end.
   
   Don’t agree  |  Completely agree
   
   (I feel she doesn’t have a problem)  |  (I feel she does have a problem)

4. How long do you feel that your partner’s drinking has been a problem? (put 0 if you don’t feel she has a problem)

   Years___________  Months___________
5. Have you done any of the following to help you cope with your partner's alcohol problem?

- Used physical exercise to help relieve stress
  - yes □ no □

- Talked to friends or family
  - yes □ no □

- Sought professional help for self (e.g. from your GP, or a counsellor)
  - yes □ no □

- Smoked more cigarettes than usual
  - yes □ no □ don’t smoke cigarettes □

If you smoke, how many cigarettes do you normally smoke in a day? _______

- Drunk more alcohol than usual
  - yes □ no □ don’t drink alcohol □

If you drink, how much alcohol do you normally drink in a typical week?

**Instructions**

Use this grid to help you think about how much you normally drink in a week, by indicating the type and amount of alcohol drunk, and when you tend to drink it.

**For example,**

<table>
<thead>
<tr>
<th>Morning</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lunchtime/Afternoon</td>
<td>1 pint cider</td>
<td></td>
<td></td>
<td></td>
<td>5 pints bitter</td>
<td>2 pints bitter</td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td>2 pints strong lager</td>
<td>Half a bottle of wine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunchtime/Afternoon</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

160
Section D. - About Your Partner

Please tick a box next to the answer that best applies.

1. Your partner's age:
   - Under 18 □ 45 to 54 □
   - 18 to 24 □ 55 to 64 □
   - 25 to 34 □ 65 and over □
   - 35 to 44 □

2. Which of the following best describes your partner?
   - Employed/self-employed full-time □
   - Employed/self-employed part-time □
   - Unemployed □
   - Full-time carer (e.g. to your children, or a dependent adult) □
   - Retired □

3. Your partner is being seen by someone from the alcohol service.
   - Have you been involved in this support? yes □ no □
   - If no, would you like to be involved? yes □ no □
   - If no, why not?

Thank you for taking the time to fill in this questionnaire.

If you have any other comments you would like to make, please use the back of this questionnaire.

Please now return this questionnaire using the provided freepost addressed envelope.
### Table D1 – Chart used to covert drinks into units of alcohol

<table>
<thead>
<tr>
<th>Type and amount of drink</th>
<th>Units of alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer or lager</td>
<td></td>
</tr>
<tr>
<td>½ pint</td>
<td>1</td>
</tr>
<tr>
<td>1 pint</td>
<td>2</td>
</tr>
<tr>
<td>Cider</td>
<td></td>
</tr>
<tr>
<td>½ pint</td>
<td>1</td>
</tr>
<tr>
<td>1 pint</td>
<td>2</td>
</tr>
<tr>
<td>Spirits</td>
<td></td>
</tr>
<tr>
<td>1 standard measure</td>
<td>1</td>
</tr>
<tr>
<td>1 bottle</td>
<td>30</td>
</tr>
<tr>
<td>Table wine</td>
<td></td>
</tr>
<tr>
<td>1 glass</td>
<td>1</td>
</tr>
<tr>
<td>1 bottle</td>
<td>7</td>
</tr>
<tr>
<td>Sherry and fortified wine</td>
<td></td>
</tr>
<tr>
<td>1 standard measure</td>
<td>1</td>
</tr>
<tr>
<td>1 bottle</td>
<td>12</td>
</tr>
</tbody>
</table>
The experiences of males with a problem-drinking female partner

In this booklet there are questions about your experiences as the male partner of a female who has been identified as having an alcohol problem. Your answers to these questions will help us to learn more about the experiences of men in your position, and to help us provide better support for partners and for female problem-drinkers.

There are no right or wrong answers to these questions – the questions ask about your personal experiences.

All your answers are confidential and anonymous, (your partner or her key-worker will not have access to this questionnaire).

Instructions
The questions are grouped into sections, with their own headings, explaining what the sections are about. We have found that most people take about 10-15 minutes to answer all the questions. In most cases you will need to tick a box against the answer that best applies to you. Please answer all the questions.

If you do not wish to fill in this questionnaire, please return it to us, blank, in the provided stamped, addressed envelope.

Questions
If you have any questions please telephone Drury House (tel: 0116 225 6350) and ask for Helen Philpott or a member of the Research Team, who will be able to help you.

Thank you for taking the time to answer these questions.
You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact Helen Philpott, or one of the Research Team members, at Drury House (tel: 0116 225 6350) if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to participate.

1. **What is the purpose of the study?**

The study aims to examine the experiences of males living with a partner who has been identified as a problem-drinker. Family life has its stresses and strains and different people cope in different ways, and all too often the partners needs are not considered. Much of the research into families and alcohol problems has focused on female partners and little is known about the experiences of male partners. By finding out about the experiences of male partners, it is hoped that services will be more able to meet their needs.

2. **Why have I been chosen?**

We are contacting females who are in contact with alcohol services, to ask them if they wish to participate in this study.

We will be recruiting participants through the following services; the Community Alcohol Team in the Leicestershire Partnership NHS Trust, the Elms Substance Misuse Clinic in the Southern Derbyshire Community and Mental Health Trust and the Alcohol Advice Centre in Leicester.

3. **What will be involved if I take part in the study?**

Taking part in the study will involve you providing the name of your male partner and a contact address for him. This information will be kept in a secure place, separately from any information regarding yourself, and will not be accessible by members of the alcohol service.

For you to provide this information, you need to ask your partner whether he is willing for you to pass on his details.
Your male partner will then be sent a questionnaire pack by post. This will include information about the study and a questionnaire asking about his experiences. The questionnaire will take approximately 20 minutes of his time to complete, and he will be asked to return it to us, by posting the questionnaire using the provided freepost addressed envelope.

If he does not return the questionnaire within two weeks, a letter will be sent to him as a reminder.

You or your partner will not be contacted again and no further information will be required.

If you would like to know the outcome of the research, a summary report will be available from the above address in September 2003. You or your partner will not be identified in any report that is written about this study.

4. **Will information obtained in the study be confidential?**

You or your partner will not be personally identified in any documents relating to the study. All information obtained will be treated with a high degree of confidentiality under the data protection act.

The questionnaires will be numerically coded, and names and addresses will be held separately in a secure location and will be destroyed at the end of the project, (in September 2003). At no time will the completed questionnaire be traceable to yourself, and it will not be accessible to any member of the alcohol team.

The study forms part of a Doctorate in Clinical Psychology qualification being undertaken by Helen Philpott, Principal Investigator, at the University of Leicester.

5. **What if I am harmed by the study?**

NHS research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. compensation is only available if negligence occurs.

6. **What happens if I do not wish to participate in this study or wish to withdraw from the study?**

It is up to you to decide whether or not to take part in this study. If you do not wish to, or do not wish your partner to participate in this study or if you or your partner wish to withdraw from the study you may do so at any time without justifying your decision and your future treatment will not be affected.

Thank you for taking the time to read this information, I hope you will now agree to participate in this study.

Helen Philpott, Principal Investigator
Dr Marilyn Christie, Supervising Investigator
Leicestershire Partnership

Service-user Identification Number for this research:

FEMALE SERVICE-USER CONSENT FORM

Male partners of female problem-drinkers

Principal Investigator: Helen Philpott

1 I confirm that I have read and understand the Female Service-user Information Leaflet Version 2, dated 18th March 2002 for the above study and have had the opportunity to discuss the details with Helen Philpott and to ask questions. The nature and purpose of the study have been explained to me and I understand what will be involved if I take part in the study.

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected.

3 I understand that NHS research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. compensation is only available if negligence occurs.

4 I have spoken to my male partner and he is willing for me to provide his name and address, and I agree to him taking part in the above study.

Name of service-user ___________________________ Date ____________ Signature ____________

Name of person taking consent (if different from principal investigator) ___________________________ Date ____________ Signature ____________

Principal Investigator ___________________________ Date ____________ Signature ____________
Dear male partner,

**Re: Male Partners Research Project**

My name is Helen Philpott and I am currently undertaking a Doctorate in Clinical Psychology qualification at the University of Leicester. One of the requirements of this course is that I carry out a piece of research.

The research I am carrying out aims to examine the experiences of males living with a partner who has been identified as a problem-drinker. Family life has its stresses and strains and different people cope in different ways, and all too often the partners needs are not considered. Much of the research into families and alcohol problems has focused on female partners and little is known about the experiences of male partners. By finding out about the experiences of male partners, it is hoped that services will be more able to meet their needs.

Your female partner is currently seeing a member of an alcohol service due to such experiences and has been approached about this study, and has given her consent for you to participate.

Please find attached an information leaflet that gives more details about the study. Read this before deciding to participate. If you have any further questions, please contact either myself, or one of the Research Team on 0116 225 6350.

If you decide to participate please complete the enclosed questionnaire and return it to us in the freepost envelope.

Thank you for taking the time to read this letter.

Yours faithfully,

Helen Philpott
Trainee Clinical Psychologist – Principal Investigator
You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact Helen Philpott, or one of the Research Team members, at Drury House (tel: 0116 225 6350) if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to participate.

Thank you for reading this.

1. **What is the purpose of the study?**

The study aims to examine the experiences of males living with a partner who has been identified as a problem-drinker. Family life has its stresses and strains and different people cope in different ways, and all too often the partners needs are not considered. Much of the research into families and alcohol problems has focused on female partners and little is known about the experiences of male partners. By finding out about the experiences of male partners, it is hoped that services will be more able to meet their needs.

2. **Why have I been chosen?**

You or your female partner are currently receiving support from a member of an alcohol service. We are hoping to get completed questionnaires from around 60 men, some of whom will be contacted through their female partner. Some male partners are in contact with services themselves, and these men will be contacted directly by their keyworker. If your female partner is in contact with a service, she was approached by her keyworker and has given her consent for you to participate.

We will be recruiting participants through the following services; the Community Alcohol Team in the Leicestershire Partnership NHS Trust, the Elms Substance Misuse Clinic in the Southern Derbyshire Community and Mental Health Trust and the Alcohol Advice Centre in Leicester.

3. **What will be involved if I take part in the study?**

Taking part in the study will involve filling in a questionnaire asking about your experiences, and returning it to us, by posting the questionnaire using the provided freepost addressed envelope. The questionnaire will take approximately 20 minutes of your time to complete.
If you do not return the questionnaire within two weeks, a letter will be sent or passed on to you as a reminder.

If you do not wish to participate please return your blank questionnaire in the provided freepost addressed envelope, and no reminder letter will be sent to you.

You or your partner will not be contacted again and no further information will be required.

If you would like to know the outcome of the research, a summary report will be available from the above address in September 2003. You or your partner will not be identified in any report that is written about this study.

4. Will information obtained in the study be confidential?

You or your partner will not be personally identified in any documents relating to the study. All information obtained will be treated with a high degree of confidentiality under the data protection act.

The questionnaires will be numerically coded, and names and addresses will be held separately in a secure location and will be destroyed at the end of the project, (in September 2003). At no time will the completed questionnaire be traceable to yourself or your partner and it will not be accessible to any member of the alcohol team.

The study forms part of a Doctorate in Clinical Psychology qualification being undertaken by Helen Philpott, Principal Investigator, at the University of Leicester.

5. What if I am harmed by the study?

NHS research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. compensation is only available if negligence occurs.

If after completing the questionnaire you feel that you would like any advice or support, please contact the Alcohol Advice Centre, Leicester (tel: 0116 222 9545).

6. What happens if I do not wish to participate in this study or wish to withdraw from the study?

It is up to you to decide whether or not to take part in this study. If you do not wish to participate in this study or if you wish to withdraw from the study, you may do so at any time without justifying your decision and without affecting your partner’s treatment or any future treatment you may receive.

Thank you for taking the time to read this information, I hope you will now agree to participate in this study.

Helen Philpott, Principal Investigator
Dr Marilyn Christie, Supervising Investigator
Dear

Re: Male Partners Research Project

You may recall that you were approached about a research project that is currently being undertaken looking at the experiences of male partners of female problem drinkers.

We have not received a completed questionnaire from you, and would like to take this opportunity to remind you about this project.

Please read the attached information leaflet which gives you more details about the study. If you have any further questions, please contact either myself, one of the Research Team on 0116 225 6350.

If you are willing to be involved in this research, please complete the enclosed questionnaire and return it to us in the freepost addressed envelope. If you do not wish to participate, please return the blank questionnaire. Please feel free to give a reason as to why you do not want to be involved.

Thank you for taking the time to read this information.

Yours faithfully,

Helen Philpott
Trainee Clinical Psychologist – Principal Investigator
Appendix K – Information on compensation

**Compensation**

To compensate you for the time it takes you to fill in this questionnaire, we will send you a £10 shop voucher. If you would like to receive this voucher, please fill in the details below, (this front sheet will be detached from the questionnaire when we receive it, so that your questionnaire will remain anonymous).

Please indicate which type of shop voucher you would like to receive.

Name....................................................................................................................

Address................................................................................................................

...........................................................................................................................

...........................................................................................................................

Halfords ☐  Boots ☐  WHSmith ☐

Thank you for taking the time to answer these questions.
Leicestershire, Northamptonshire and Rutland
Health Authority

10 May 2002

Miss Helen Philpott
Trainee Clinical Psychologist
Centre for Applied Psychology
Clinical Section The Ken Edwards Building
University of Leicester
University Road
Leicester LE1 7RH

Dear Miss Philpott

Male Partners of Female Problem-Drinkers – our ref. no. 6682

Further to your application dated 26 March, you will be pleased to know that the Leicestershire Research Ethics Committee at its meeting held on the 3 May 2002 approved your application to undertake the above mentioned research.

The Committee would suggest that the female problem drinker be given a consent form for their male partner to sign together with a stamped addressed envelope to enable this to be returned to the researcher.

Your attention is drawn to the attached paper which reminds the researcher of information that needs to be observed when Ethics Committee approval is given.

The Committee commented that they were impressed with the presentation of your application.

Yours sincerely

P G Rabey
Chairman
Leicestershire Research Ethics Committee

(NB All communications relating to Leicestershire Research Ethics Committee must be sent to the Committee Secretariat at Leicestershire, Northamptonshire and Rutland Health Authority. If, however, your original application was submitted through a Trust Research & Development Office, then any response or further correspondence must be submitted in the same way.)
Appendix M – Letters stating ethical approval

Southern Derbyshire
Local Research Ethics Committee

Chairman: Dr A W A Crossley MB ChB FRCA
Administrator: Jenny Hancock ext 6209 (direct dial from Derby hospitals 16-6209)
Direct fax: 01332 363963
email: jenny.hancock@mail.sderby-ha.trent.nhs.uk

18 April 2002

Ms Helen Philpott
Trainee Clinical Psychologist
Centre for Applied Psychology, Clinical Section
University of Leicester
University Road
Leicester
LE1 7RH

Dear Ms Philpott

SDLREC REF: 0204/472
MALE PARTNERS OF FEMALE PROBLEM-DRINKERS

The Southern Derbyshire Local Research Ethics Committee reviewed your application on 16 April 2002. The documents reviewed were as follows:

Application form dated 26 March 2002
Research Protocol dated 18 March 2002
Letter from Professor E Miller dated 25 March 2002
Female patient information leaflet version 2 dated 18 March 2002
Female patient consent form version 2 dated 18 March 2002
Female patient consent form agreeing to approach to male partner
Male participant information leaflet, version 1 dated 18 March 2002
Questionnaire pack dated 18 March 2002, including alternative front page if participants are to be compensated for their time, dated 18 March 2002
Layman’s summary dated 18 March 2002

The members of the committee present agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, pleased to be able to inform you that the study was approved on the understanding that you will follow the conditions set out below:

Conditions

- You do not undertake this research in an NHS organisation until the relevant NHS management approval has been gained as set out in the Framework for Research Governance in Health and Social Care.
- You do not deviate from, or make changes to, the protocol without prior written approval of SDLREC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases SDLREC should be informed within seven days of the implementation of the change.
- You complete and return the standard progress form to SDLREC one year from the date on this letter and thereafter on an annual basis. This form should also be used to notify SDLREC when your research is completed within three months of completion.
18 April 2002

Ms Helen Philpott

- If you decided to terminate this research prematurely, you send a report to SDLREC within 15 days, indicating the reason for the early termination.
- You advise the SDLREC of any unusual or unexpected results that raise questions about the safety of the research.

Any comments Southern Derbyshire LREC wished to make are contained in the attached REC Response Form. The project must be started within three years of the date on this letter.

Please quote the SDLREC reference number (shown above) in all future correspondence on this study.

Yours sincerely

[Signature]

A W A Crossley
Chairman
Southern Derbyshire Local Research Ethics Committee

cc Mrs Lesley Legg, Research Co-ordinator, SD Community and Mental Health Service Trust
Dr Marilyn Christie, Consultant Clinical Psychologist and Team Leader, Leicestershire NHS Drug and Alcohol Service

Enc. REC Response Form
List of members present and members who submitted written comments
23 October 2002

Ms Helen Philpott
Trainee Clinical Psychologist
Centre for Applied Psychology, Clinical Section
University of Leicester
University Road
Leicester
LE1 7RH

Dear Ms Philpott

SDLREC REF: 0204/472
MALE PARTNERS OF FEMALE PROBLEM-DRINKERS

I refer to your letter of 8 October in response to Dr Crossley’s letter of 10 September relating to the compensation of participants in the above study.

Thank you for confirming that the £10 voucher is not being used as an inducement to take part in the study, but rather as a “thank you” for completing the questionnaire. Acting on delegated authority from the Committee, I am now happy to approve the amendment and I confirm that you may now proceed with the modified study in the Southern Derbyshire Health Authority District.

I will report this information to members at the next meeting of the Southern Derbyshire Local Research Ethics Committee.

Yours sincerely

P Korczak
Chairman
Southern Derbyshire Local Research Ethics Committee
Leicestershire, Northamptonshire and Rutland
Strategic Health Authority

Our Ref: PR/sl/6682
12 February 2003

Ms H Philpott
Trainee Clinical Psychologist and Principal Investigator
Centre for Applied Psychology – Clinical Section
The Ken Edwards Building
University of Leicester
Leicester LE1 7RH

Dear Ms Philpott

Male partners of female problem drinkers – our ref: 6682

I am in receipt of the protocol amendment dated 6th January 2003 detailed as follows:

Appendix A, B, D, E, F

By Chairman’s action I hereby approve these amendments.

Your application has been given a unique reference number. Please use it on all correspondence with the REC.

Yours sincerely,

[Signature]

Dr Peter Rabey
Chairman – Leicestershire Local Ethics Committee

(N.B. All communications related to Leicestershire Research Ethics Committee must be sent to the Committee Secretariat at Leicestershire, Northamptonshire and Rutland Health Authority. If, however, your original application was submitted through a Trust Research & Development Office, then any response or further correspondence must be submitted in the same way).
### Table O1 - Additional comments added at the end of the Coping Questionnaire

<table>
<thead>
<tr>
<th>Participant number</th>
<th>Comment made</th>
<th>Type of coping the comment relates to (using the typologies presented by Orford et al., 1992; 1998)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>since it became identified as a problem health-wise we both went off the boil sexually – this led to her feeling unloved and unwanted, which she certainly is not. So I am working on my inadequacies to cope with the worry, in order to get back a good relationship</td>
<td><strong>Tolerant coping</strong> (self-blame aspect) <strong>Engaged coping</strong> (active &amp; supportive)</td>
</tr>
<tr>
<td>2</td>
<td>since the problem was ‘identified’ we drink more tea / coffee with friends who come round – most of whom are aware of the situation, but this grew naturally – I haven’t ‘forbid’ drink in the house</td>
<td><strong>Engaged coping</strong> (active support)</td>
</tr>
<tr>
<td>5</td>
<td>taken away all her credit cards and cheque book</td>
<td><strong>Engaged coping</strong> (controlling)</td>
</tr>
<tr>
<td>5</td>
<td>loss of temper</td>
<td><strong>Engaged coping</strong> (controlling)</td>
</tr>
<tr>
<td>8</td>
<td>have often thought that my being in her life has made her problem worse</td>
<td><strong>Tolerant coping</strong> (self-blame)</td>
</tr>
<tr>
<td>10</td>
<td>Recently her alcohol consumption has been alot [sic] less</td>
<td>Not seen as a coping behaviour</td>
</tr>
<tr>
<td>11</td>
<td>asked her friends to contact her</td>
<td><strong>Engaged coping</strong> (active &amp; supportive)</td>
</tr>
<tr>
<td>15</td>
<td>on occasion become very aggressive with her</td>
<td><strong>Engaged coping</strong> (controlling)</td>
</tr>
<tr>
<td>17</td>
<td>could have been more supportive in her work and with her family</td>
<td>Not seen as a coping behaviour</td>
</tr>
<tr>
<td>19</td>
<td>I originally felt in the depths of despair but with the help of Al-Anon came to accept it has [sic] illness</td>
<td><strong>Tolerant coping</strong> (‘feeling...despair’ reflects inactivity) <strong>Withdrawal coping</strong> (going to Al-Anon) <strong>Engaged coping</strong> (active)</td>
</tr>
<tr>
<td>21</td>
<td>feel depressed</td>
<td><strong>Tolerant coping</strong> (the emotion relates to inactivity)</td>
</tr>
<tr>
<td>22</td>
<td>have tended to put myself first</td>
<td><strong>Withdrawal coping</strong> (independence)</td>
</tr>
<tr>
<td>24</td>
<td>kept taking her to GP to get professional help</td>
<td><strong>Engaged coping</strong> (controlling)</td>
</tr>
<tr>
<td>25</td>
<td>we miss 90% of family functions i.e. birthdays, wedding, etc</td>
<td><strong>Engaged coping</strong> (controlling)</td>
</tr>
<tr>
<td>27</td>
<td>gone away for occasional nights</td>
<td><strong>Withdrawal coping</strong> (independence)</td>
</tr>
<tr>
<td>27</td>
<td>made rash decisions e.g. sell the car and buy another “less” prestigious car without telling her</td>
<td><strong>Engaged coping</strong> (reflects the emotional component - angry and hurt feelings)</td>
</tr>
<tr>
<td>28</td>
<td>watered down drink when I found it.</td>
<td><strong>Engaged coping</strong> (controlling)</td>
</tr>
<tr>
<td>28</td>
<td>taken leave from work to support her attempt to stop drinking.</td>
<td><strong>Tolerant coping</strong> (leave from work is self-sacrificing) <strong>Engaged coping</strong> (supportive part)</td>
</tr>
</tbody>
</table>
Meeting the assumptions for the Mann-Whitney U test comparing the male and female partner samples

The Mann-Whitney U test assumes that there is homogeneity of the variances of the two groups to be compared. The analysis that was planned was to compare the Coping Questionnaire scores of the male partner and the female partner samples. Table P1 shows the variances of the Coping Questionnaire scores for two samples.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Variances of the Coping Questionnaire scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total coping</td>
</tr>
<tr>
<td>Male partners</td>
<td>28</td>
<td>359.471</td>
</tr>
<tr>
<td>Female partners</td>
<td>27</td>
<td>112.943</td>
</tr>
</tbody>
</table>

Table P1 — Variances of the Coping Questionnaire scores for the male and female partner samples.

Except for the tolerant coping score the variances are not seen as homogeneous. Where variances are not homogeneous Clark-Carter (1997) suggests ranking the data of the two groups together and checking that the variances of the ranks of the two groups are not more than three times the size of each other. Table P2 shows the variances of the ranked data.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Variances of the ranked data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total coping</td>
</tr>
<tr>
<td>Male partners</td>
<td>28</td>
<td>341.527</td>
</tr>
<tr>
<td>Female partners</td>
<td>27</td>
<td>177.798</td>
</tr>
</tbody>
</table>

Table P2 — Variances of the Coping Questionnaire scores for the different Causal Dimensions Scale groups.

This shows that the variances of the two groups to be compared were all within three times the difference of each other. Therefore the Mann-Whitney U test was seen as valid and appropriate.
Meeting the assumptions for the Mann-Whitney U test comparing the ages of the female problem drinkers in the current study and male problem drinkers in the Orford et al. (1998) sample

The Mann-Whitney U test assumes that there is homogeneity of the variances of the two groups to be compared. The analysis that was planned was to compare ages of the female problem drinkers in the current study and male problem drinkers in the Orford et al. (1998) sample.

Data on ages was collected in age ranges as shown in Table 9. The different age ranges were assigned number 1 to 5, giving the data sets shown in Table Q1. This shows the variances of the two sets of data. Where variances are not homogeneous Clark-Carter (1997) suggests ranking the data of the two groups together and checking that the variances of the ranks of the two groups are not more than three times the size of each other. The variances of the ranked data were 254.74 for the male problem drinkers and 150.643 for the female problem drinkers. The larger of these variances is not three times the smaller, therefore the Mann-Whitney U Test is seen as valid.

<table>
<thead>
<tr>
<th>Female drinkers in the current study N=28</th>
<th>Male drinkers in the Orford et al. (1998) sample N=27</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
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<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Variance = 0.619 Variance = 1.103

Table Q1 – Data set of the ages of the female and male problem drinkers based on the frequencies of the age range.
Table R1 - Main cause / reason given by the male partner for female’s problem drinking

<table>
<thead>
<tr>
<th>Participant number</th>
<th>Main reason / cause given by male partner as to why his partner drinks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>lifelong problems with family and relationships with ex-husband / children and parents &amp; partners</td>
</tr>
<tr>
<td>2</td>
<td>some incident(s) that occurred during her childhood, definitely abusive, possibly sexual, highly possibly over-protective parents. So that now these are reflected in fear (dreams) and rebelliousness (actions)</td>
</tr>
<tr>
<td>3</td>
<td>depression</td>
</tr>
<tr>
<td>4</td>
<td>depression</td>
</tr>
<tr>
<td>5</td>
<td>depression / stress</td>
</tr>
<tr>
<td>6</td>
<td>no reason / cause given</td>
</tr>
</tbody>
</table>
| 7                  | ? don’t know  
(NB this participant did not complete the Causal Dimensions Scale) |
| 8                  | her depression, her self-loathing, her treatment for the above not working |
| 9                  | she worries about anything and everything |
| 10                 | habit |
| 11                 | lack of self-esteem, anger at the world, unhappiness  
('lack of self-esteem’ was highlighted as the main cause) |
| 12                 | boredom – I work shifts and personal problems from years ago playing on her mind |
| 13                 | mental state due to childhood experiences |
| 14                 | depression |
| 15                 | loveless marriage. I show little affection to her |
| 16                 | life and stress |
| 17                 | lack of self-esteem caused by her mother |
| 18                 | depressed |
| 19                 | our son leaving home, getting married to a girl my wife dissapproved [sic] of |
| 20                 | other people calling with [sic] drink problems |
| 21                 | depression |
| 22                 | says she uses it to blot things out |
| 23                 | her father |
| 24                 | low self-esteem, addictive substance abuse |
| 25                 | she suffers from depression which is treated on prescription drugs but this is sometimes used as an excuse |
| 26                 | mainly lack of self confidence |
| 27                 | lack of self-esteem |
| 28                 | she uses it as a sedative to avoid facing emotional problems |
Meeting the assumptions for the Mann-Whitney U test comparing the causal attributions and the Coping Questionnaire scores

The Mann-Whitney U test assumes that there is homogeneity of the variances of the two groups to be compared. The analysis that was planned was to compare the Coping Questionnaire scores of those who gave rating suggesting stable and uncontrollable (unchangeable) attributions with those who made unstable and controllable (changeable) attributions. Table S1 shows the variances of the Coping Questionnaire scores for the two groups.

<table>
<thead>
<tr>
<th>N</th>
<th>Variances of the Coping Questionnaire scores</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total coping</td>
<td>Engaged coping</td>
<td>Tolerant coping</td>
</tr>
</tbody>
</table>

Stable and uncontrollable attributions (unchangeable)  
5 251.70 105.20 23.50 41.80

Unstable and controllable attributions (changeable)  
4 526.25 172.92 56.25 30.92

Table S1 – Variances of the Coping Questionnaire scores for the different Causal Dimensions Scale groups.

Where variances are not homogeneous Clark-Carter (1997) suggests ranking the data of the two groups together and checking that the variances of the ranks of the two groups are not more than three times the size of each other. Table S2 shows the variances of the ranked data. This shows that the variances of the two groups to be compared were all within three times the difference of each other. Therefore the Mann-Whitney U test was seen as valid and appropriate.

<table>
<thead>
<tr>
<th>N</th>
<th>Variances of the ranked data</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total coping</td>
<td>Engaged coping</td>
<td>Tolerant coping</td>
</tr>
</tbody>
</table>

Stable and uncontrollable attributions (unchangeable)  
5 5.00 6.70 5.00 8.30

Unstable and controllable attributions (changeable)  
4 13.33 8.67 12.23 8.33

Table S2 – Variances of the Coping Questionnaire scores for the different Causal Dimensions Scale groups.
Appendix T

Meeting the assumptions for the Mann-Whitney U test comparing the different levels of alcohol consumption and the Coping Questionnaire Scores

The Mann-Whitney U test assumes that there is homogeneity of the variances of the two groups to be compared. The analysis that was planned was to compare the Coping Questionnaire scores of the different types of drinkers (i.e. comparing abstinent with light and with heavy drinkers, and comparing light and heavy drinkers).

Table T1 shows the variances of the Coping Questionnaire scores for the abstinent, light and heavy drinkers. This shows that there were large differences in the variances of the coping scores.

<table>
<thead>
<tr>
<th>N</th>
<th>Total coping</th>
<th>Engaged coping</th>
<th>Tolerant coping</th>
<th>Withdrawn coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinent group</td>
<td>3</td>
<td>52.333</td>
<td>121.333</td>
<td>1.000</td>
</tr>
<tr>
<td>Light drinkers</td>
<td>21</td>
<td>408.048</td>
<td>144.157</td>
<td>36.333</td>
</tr>
<tr>
<td>Heavy drinkers</td>
<td>4</td>
<td>139.000</td>
<td>67.583</td>
<td>16.333</td>
</tr>
</tbody>
</table>

*Table T1 – Variances of the Coping Questionnaire scores for the three drinking groups.*

Where variances are not homogeneous Clark-Carter (1997) suggests ranking the data of the two groups together and checking that the variances of the ranks of the two groups are not more than three times the size of each other. Table T1 shows the variances of the ranked data.

For the comparison of the abstinent and light drinkers, Table T2 shows that the variances of the ranked data for the total coping scores and the tolerant scores are more than three times different from each other. Therefore the assumptions are not met for the Mann-Whitney U test and only results for the comparison of the engaged and withdrawn coping scores are presented in the results section.

For the comparison of the abstinent and heavy drinkers, all the variances of the ranked data meet the assumptions for the U test and all the results of this analysis are presented.

For the comparison of the light and heavy drinkers, Table T2 shows that the assumptions for the U test are not met for the total coping and the tolerant coping comparisons, therefore only the analysis for engaged and withdrawn coping comparisons are presented.
### Table T2 – Variances of the ranked data of the coping scores for the planned comparisons of the different drinking groups.

<table>
<thead>
<tr>
<th>Comparison of drinking groups</th>
<th>N</th>
<th>Total coping</th>
<th>Engaged coping</th>
<th>Tolerant coping</th>
<th>Withdrawn coping</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comparison of abstinent and light drinkers</strong></td>
<td>Abstinent group</td>
<td>3</td>
<td>10.333</td>
<td>34.333</td>
<td>2.250</td>
</tr>
<tr>
<td></td>
<td>Light drinkers</td>
<td>21</td>
<td>56.462</td>
<td>51.437</td>
<td>53.404</td>
</tr>
<tr>
<td><strong>Comparison of abstinent and heavy drinkers</strong></td>
<td>Abstinent group</td>
<td>3</td>
<td>1.000</td>
<td>7.000</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>Heavy drinkers</td>
<td>4</td>
<td>1.500</td>
<td>4.667</td>
<td>1.333</td>
</tr>
<tr>
<td><strong>Comparison of light and heavy drinkers</strong></td>
<td>Light drinkers</td>
<td>21</td>
<td>55.298</td>
<td>57.014</td>
<td>55.650</td>
</tr>
</tbody>
</table>
Meeting the assumptions for the regression analyses

Choice of variables and model
Regression analysis assumes independence of all the values of the dependent variable (Field, 2001). In this case the dependent variable was the Coping Questionnaire, the values of which were independent as each came from a separate subject.

The independent variables used in a regression analysis need to be of interval data (Field, 2001) therefore the Causal Dimensions Scale was excluded from this analysis as its data was ordinal.

Therefore the following independent variables were entered into the regression analysis: the extent to which the male agreed that his female partner’s drinking was problematic; the duration of the drinking problem; and the amount the male reported drinking in a typical week. These were seen as valid as they all had a positive variance as shown in Table U1 (Field, 2001).

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extent to which males agreed that partner's drinking was problematic</td>
<td>27</td>
<td>7.74</td>
<td>2.91</td>
</tr>
<tr>
<td>Duration of the problem in months</td>
<td>27</td>
<td>87.22</td>
<td>4004.95</td>
</tr>
<tr>
<td>How much males' had drunk in a typical week</td>
<td>28</td>
<td>14.68</td>
<td>122.91</td>
</tr>
</tbody>
</table>

Table U1 – Means and variances for the three independent variables used in the regression analysis.

There were no correlations between the independent variables (see Table 23) therefore a forced entry model of regression was used, as opposed to a stepwise model (Clark-Carter, 1997).

Validity of the results from the regression analysis
Figures U1, U2, U3 and U4 show histograms of the residuals from the separate regression analyses. This is seen as a valid way of checking whether the residual are normally distributed and have a mean of zero (Bland, 1995). Figures U1 and U2 show that the residuals are normally distributed and have a mean of zero, therefore these analyses are seen as valid.
Figures U1 and U2 show that the residuals from the regression analyses looking at the engaged coping subscale and the withdrawn coping subscale are not normally distributed, therefore these analyses are seen as not meeting the assumptions for linear regression and are not reported.
Figures U5 and U6 show the standardised predicted values plotted against the standardised residuals. The random nature of the data points shows that the assumptions of homoscedasticity have been met (Bland, 1995; Clark-Carter, 1997).
Figure U5 - Scatterplot showing the standardised predicted values plotted against the standardised residuals for the regression analysis looking at the predictors of the total coping score.

Figure U6 - Scatterplot showing the standardised predicted values plotted against the standardised residuals for the regression analysis looking at the predictors of the tolerant coping score.

The last assumption is that the errors are independent. The Durbin-Watson value for the regression analysis looking at the predictors of the total coping score was 2.024 and that for the tolerant coping score was 1.697. Values between 1 and 3 are seen as acceptable (Field, 2001) therefore this assumption was also met.