CLOSING THE REVOLVING DOOR:

A QUALITATIVE ANALYSIS OF RECOVERED HEROIN AND COCAINE ADDICTS' EXPERIENCE OF RECOVERY AND ABSTINENCE

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DECLARATION

I declare that this thesis is my own unaided work. It is submitted for the degree of Master of Arts in Counselling Psychology at the University of Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other university.

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ABSTRACT

A now sizeable body of substance-abuse research has examined the factors that contribute to a relapse; however, less research has been conducted on identifying factors in patients who do not relapse. In South Africa, relatively limited qualitative research is available on relapse, and substance abuse in general. This study assessed recovered heroin and cocaine individuals in order to identify some of the factors that account for their ability to remain drug-free. Individual semi-structured interviews were conducted with the participants, each of whom had remained abstinent from their drug of choice for at least 10 months. These interviews were audio recorded and transcribed, and then analysed for themes using thematic content analysis. Findings of the study included the manner in which the recovered individual's sense of agency vacillated between external and internal modes of attribution for their recovery and that systemic support was perceived as critical to continued abstinence. These findings imply that treatment providers consider both the risk for and protective factors against relapse as part of integrated systems in planning interventions.

CONTENTS

CHAPTER ONE: INTRODUCTION

Substance abuse and dependence exert a tremendous burden on South Africa's healthcare systems and are a major public health concern. While treatment programmes often contribute to a reduction in psycho-social and substance use problem severity, many of the individuals who leave these centres return to their habit soon after discharge (McKay, Rutherford, Alterman, Cacciola, & Kaplan, 1995). Although a sizeable portion of research has been conducted with those patients who relapse, very little research has targeted those individuals who are able to maintain abstinence. The introductory chapter will discuss the aims and rationale for this research. It will also provide a short breakdown of the contents of the subsequent chapters

1.1 Rationale

The 'revolving door' syndrome in substance dependency has been relatively well documented in the literature (Grella, Hser, & Hsieh, 2003; Janse van Rensburg, 1998; Scott, Foss, & Dennis, 2005). It refers to the cyclical admission, release, and readmission of substance users to treatment facilities. This research aimed to consider the process from the other side of this revolving door, by studying those persons who have self-identified as recovered and thus are able to maintain a healthy lifestyle i.e. remain abstinent. As such, it aimed to contribute further to an understanding of the experiences of individuals recovering from drug dependence who have managed to escape the syndrome through recovery and sustained abstinence.

Relapse rates of substance abusers are extremely high, characterised by cyclical swings of use, rehabilitation, abstinence, relapse, abstinence etc. (Gossop, Stewart, Browne & Marsden, 2002; Scott et al., 2005; Walton, Reischl, & Ramanthan, 1995). A study by Gossop et al (2002) found that "more than half of those who used heroin did so for the first time within 3 days after leaving treatment, and three-quarters did so within 1 week" (p. 1262). This high relapse rate is the primary motivating factor for conducting this research. It seems abundantly clear that there are gaps within the treatment rehabilitation programmes that are not being satisfactorily addressed. It is hoped that by examining those individuals who are able to maintain a healthy

lifestyle, new ideas and principles may emerge which may be integrated into the country's clinical treatment programmes. This could possibly help to reduce the relapse rate. Furthermore, substance abusers place a tremendous financial and social strain on a country like South Africa, already burdened with formidable health demands.

Abstinence is a primary marker of recovery and as such, is the main goal of drug and alcohol treatment programmes. Yet it remains elusive for many drug dependent people who enter treatment facilities in our county, and around the world. It therefore seems logical to examine those individuals who have been discharged from these facilities who are able to refrain from returning to their previous drug abuse. Exploring the principles that they employ to cope with the constant reminders and cravings that they experience would therefore be important, and would be useful for other not-so-fortunate individuals who seem to be caught in the relapse to discharge cycle.

As the aim of the current research was to obtain a deeper understanding of the recovering individual's experiences, and not to narrow down specific cause-effect relationships, an emic approach was adopted. This appears relatively novel as most of the research in this field has been written from a classical positivistic etic approach (McMahon, 2001; Sinha, 2001; Walton, Blow & Booth, 2000). While qualitative analysis implies a measure of inductive theory building, system's theory will be predominantly utilised to interpret the resultant data in understanding recovery and abstinence in people who were previously dependent on heroin and cocaine.

As noted already, one of the broadest aims of this research was to acquire an in-depth account of the process of recovery from those individuals who had been able to maintain abstinence. Since there is a dearth of research in this particular field, a further intention of the study was to provide an initial exploration of this topic and lay some possible foundations that additional studies could build upon. Further aims were to recognize some of the motivating factors that these individuals used to remain abstinent, as well as to identify the specific coping mechanisms that they found most useful when faced with opportunities to use drugs again. In keeping with system's theory (which formed the theoretical framework for this research), a further

aim was to determine the levels of support that they experienced from family, friends, and work colleagues. The final goal was to identify aspects of their treatment programmes that were especially beneficial for them.

1.2 Structure of the research report

Chapter two of this research report provides the literature survey for the study. It begins with an epidemiological overview of the substance abuse problem, both internationally and locally. Thereafter, definitions of substance abuse, addiction, relapse and recovery are made, which are followed by a discussion of cocaine and heroin (the drugs used by the participants). Subsequent to this, a large portion of the literature review involves an outline of a number of key theories that are important when considering substance abuse, dependence and relapse. This is followed by an overview of the theoretical model (systems theory) that forms the foundation for this research. Finally, the chapter concludes with a synopsis of a number of crucial studies that have been conducted in the field around the topics of substance abuse, abstinence and relapse.

The methodology chapter (chapter three) provides a summary of the sampling and data collection methods used, as well as an outline of the transcription and data analysis techniques (specifically thematic content analysis). The chapter is brought to a close with a short discussion concerning qualitative research and reflexivity.

Chapter four presents a discussion of the themes that were identified in the thematic content analysis. In addition, it seeks to integrate the results with appropriate theory, noting similarities or differences between the results and the broader literature. It discusses the following themes: beginnings of drug use, identity pre-treatment, identity post-treatment (which includes themes around a genuine self, coping mechanisms, emotions, and the process of recovery). Themes that overlapped between identity pre-treatment and identity post-treatment were avoidance, control, consequences, and perceptions of drug.

In the final chapter, concluding comments are made concerning the themes that were identified and discussed in this study. The limitations of the study are

examined, and possible recommendations are made which should serve to improve the efficacy and outcomes of treatment programmes.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

As one of the aims of the study is to broaden understandings of substance abuse relapse, as well as to build on previous research, it is logical that a discussion of past and present research be undertaken. Since there is not much research that has been conducted in South Africa on this topic, this section therefore serves as a content platform upon which the current research will build upon.

Firstly, international and local epidemiological data are presented in order to demonstrate the extent of the problem and contextualise this research. Thereafter, definitions of substance abuse, relapse and recovery will be presented. The focus of the literature review then turns to a more detailed examination of the two drugs specific to this study, namely cocaine and heroin. A description of theories and models of addiction and recovery then ensues. The review concludes with an examination of a number of international studies on substance abuse, abstinence and relapse.

2.2 International and Local Statistics

The World Drug Report, published by the United Nations Office on Drugs and Crime, presents a reliable and comprehensive account of the trends and estimates on production, trafficking and consumption of numerous drugs. A discussion of the global trends reported by the 2008 World Drug Report concerning heroin and cocaine ensues[1].

Regarding heroin, the report notes that while there has been a significant growth in the production of opiates, global consumption has remained relatively stable – a marginal increase in annual prevalence was identified (from 0.37 percent of the population age 15 – 65 in 2005, to 0.39 percent in 2006). The total number of opiate users at the global level is estimated at around 16.5 million people, with more than half of the world's opiate using population living in Asia (9.3 million). Of these 16.5

[1] It needs to be noted that the World Drug Report of 2008 indicates that people severely drug dependent constitute approximately 0.6 percent of the world's adult population (an estimated 26 million people).

million people, an estimated 72 percent consume heroin (approximately 12 million people).

Cocaine consumption was estimated at 0.4 percent of the global population in 2006/2007, approximately 16 million people aged between 15 and 64. North America had the largest numbers of cocaine users (7.1 million people, or 45 percent of the world's total), followed by West and Central Europe (24 percent) and South America (19 percent). The data indicated a trend towards a global stabilisation of cocaine use.

The report estimated that within Africa, approximately 1.3 million people use opiates, and approximately 1.1 million people use cocaine. Both these estimates are below the global average.

In South Africa, heroin and cocaine abuse and dependence are both extremely prevalent, and their use places a tremendous burden on the healthcare services of this country (Van der bijl, 2004). Legett (2004) cites a study done by the Medical Research Council and the Institute for Security Studies. The study found that "nearly half the people arrested in sites in Durban, Cape Town, and Johannesburg tested positive for some illegal drug in their urine" (Legett, 2004, p. 1). Thus there seems to be a close link between drug abuse and crime within the country.

The South African Community Epidemiology Network on Drug Use (SACENDU) publishes bi-annual reports describing the incidence and prevalence of drugs and alcohol use. Their statistics are reliant on data captured from various treatment centres throughout the country. An overview of their latest report – phase 23 (July – December 2007), will take place, specifically examining their results observed for Gauteng. This data only records people who seek help for their drug dependence and so does not capture the full extent of substance abuse. However, the results are informative and they do reveal specific trends.

Carelsen & Potgieter (2007) note that a total of 3053 patients were treated in Gauteng during July to December 2007 for drug dependence. Of this population, 80 percent were male, and 20 percent were female. Concerning the ethnic group of these patients, 52 percent were White, 34 percent were African, 11 percent were

Coloured, and three percent were Asian. The age of the largest (17 percent) portion of these patients ranged from 15 – 19 (n=526). While the primary substance of abuse (47 percent) for both genders was alcohol (n=1434), dagga (19 percent) ranked second (n=590), crack (10 percent) third (n=300), and heroin (10 percent) fourth (n=292). There was only one category where women outnumbered men – Over-the-counter and Prescription medication (OTC/PRE) (40 percent males, 60 percent females).

Specifically relevant for this research report is the fact that 26 percent of patients treated throughout Gauteng during July to December 2007 were readmissions i.e. they had already been through the detoxification and rehabilitation process.

2.3 Definitions of substance abuse, addiction relapse and recovery

There are a number of definitions of substance abuse and substance dependence offered in the literature. The Diagnostic and Statistical Manual IV-TR (DSM IV-TR) "defines substance abuse in terms of how significantly it interferes with the user's life" (Barlow & Durand, 2005, p. 381). Differentiation must be noted between simply using the substance, and being dependant[2] on that substance. "The essential feature of substance dependence is a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems" (American Psychiatric Association, 2000, p. 192). Generally, the individual who is dependent on a particular drug is "physiologically dependent on the drug, or drugs, requires greater and greater amounts of the drug to experience the same effect (tolerance), and will respond physically in a negative way when the substance is no longer ingested (withdrawal)" (Barlow & Durand, 2005, p. 381).

There are numerous contentions in the literature about what exactly constitutes a relapse (See Donovan, 1996; Marlatt & George, 1984; Saunders & Allsop, 1987). Miller (1996) goes as far as saying that the term relapse "implicitly pathologizes what is in fact a rather common event in the course of behavior change, and embodies an

[2] Throughout this research report, the words 'drug dependence' are utilised as far as possible in order to avoid the pejorative connotations associated with the colloquial use of the word 'addiction'.

unrealistic and inaccurate conception of how successful change occurs over time" (p. S15). It is important therefore that this study provides a definition of relapse. McKay, Franklin, Patapis & Lynch (2006) note that there is still no standard definition of relapse. The authors illustrate their point with examples from relapse-related studies – these studies sometimes define relapse as any use at all after a period of abstinence, or at least one day of heavy use, or a combination of substance use and negative consequences. Marlatt & George (1984) view relapse "as a transitional process, a series of events that may or may not be followed by a return to pretreatment baseline levels of target behavior" (p. 263). In addition, Saunders & Allsop (1987) clarify that a "relapse occurred because the abstinent problem drug user encountered a situation which overwhelmed the coping skills of the individual concerned and use of the drug was then reinstated" (p. 421). For the purposes of this study, relapse will be defined as the use of any intoxicating substance after discharge from a treatment facility. While this definition does point to an 'all-or nothing' view of relapse, this perception does seem to be consistent with what a number of the participants in the study would consider to be a relapse.

As already mentioned, one of the main goals of treatment is to encourage the drug dependent individual to refrain totally from using alcohol or drugs i.e. abstinence (Marlatt & George, 1984). It is argued that when an individual does break the abstinence rule, he experiences a decrease in self-esteem and guilt, and blames himself, which actually leads to further drug usage. This has been called the Abstinence Violation Effect (AVE) (Donovan, 1996; Marlatt & George, 1984). A set duration of abstinence also needs to be demarcated. Since the length of abstinence falls along a continuum, the researcher reviewed three studies (Gossop et al, 2002; Hser, Joshi, Anglin, & Fletcher, 1999; Llorente del Pozo, Fernandez Gomez, Gutierrez Fraile, & Vielva Perez, 1998) which compared relapsed individuals with those that maintained abstinence. The initial two studies used 12 months as their cutoff point, and the third used seven months as the cutoff. Therefore, the average number of months between the three studies is 10.3 months of abstinence post treatment. Hence, to be included in the sample for this research, 10 months of abstinence was the minimum amount of time required.

2.4 Cocaine and Heroin

As recovered cocaine and heroin users are the specific target population, a somewhat concise understanding of these two drugs is appropriate. Both drugs fall into the category of psychoactive substances.

Cocaine is categorized as a central nervous stimulant, and it is a naturally produced drug extracted from the leaves of the coca plant. Benshoff & Janikowski (2000) define stimulants as

> those drugs that act directly on the central nervous system to create an increased state of electrical activity and accelerated mental processes. The subjective intoxicating effects of stimulants consist of mood elevation, feelings of pleasure or euphoria, increased energy and alertness, increased sense of well-being and self-confidence, and decreased fatigue and appetite (p. 98).

Numerous long term effects of cocaine use have been noted by The Medical Research Council (2008), including dependence and cravings, feelings of irritability, depression and paranoia, significantly increased health risks, diarrhea, respiratory problems, damaged nasal septum, and a decreased ability of the body to fight infections. Unsafe sexual behaviour, as well as the diseases associated with this behaviour, imply further risks to its use.

Heroin is classified as a narcotic, and further classified as an opiate. Initially, the drug was developed in the hope of being an effective pain killer (Benshoff & Janikowski, 2000), but it was removed from the market shortly after being released because of its extremely addictive qualities.

Short term effects of heroin use include euphoria, pain suppression, drowsiness, relaxation, and occasionally hallucinations (Bain, 2004; Benshoff & Janikowski, 2000). Dependence and withdrawal symptoms (such as severe muscle cramps, diarrhea, irritability and depression), coma, HIV infection, respiratory problems, and impaired psychological developments represent commonly reported symptoms associated with long-term heroin use (Bain, 2004; Medical Research Council, 2008).

2.5 Theories and models of addiction, recovery and relapse

Diagnostically, the DSM IV-TR categories that the particular participants for this study would have fallen under are the categories of Cocaine dependence disorder,

and Opioid dependence disorder (APA, 2000). West (2001) points out that "the severity of the medical, psychological and social harm that can be caused by addiction, together with the fact that it violates the individual's freedom of choice, means that it is appropriate to consider it to be a form of psychiatric disorder: a disorder of motivation" (p. 3). Like all psychiatric disorders, "multiple interacting factors influence drug-using behaviour and the loss of flexibility with respect to decisions about using a given drug" (Sadock & Sadock, 2007, p. 385). Furthermore, motivations for using different drugs vary from individual to individual (Sadock & Sadock, 2007). What follows now is a theoretical discussion of the various attempts that have been made to conceptualise the aetiology of these disorders.

West (2001) provides a review of the theories of drug dependence. He divides these theories into five groups, namely (1) theories that focus on conceptualisation and general processes, (2) theories that focus on effects of addictive stimuli, (3) theories that focus on individual susceptibility, (4) theories that focus on environmental factors, and (5) theories that focus on recovery and relapse.

2.5.1 Theories that focus on conceptualisation and general processes

Within this group fall theories that seek to explicate and provide some insight into the conceptualisation and general processes of drug dependence. These theories offer biological, social, or psychological (psychodynamic and cognitive) formulations in order to understand the nature of addiction.

Bejerot (1980) sought to explain addiction as a natural drive of the brain when it encounters a pleasurable substance or activity. "The simplest way of regarding a drug addiction is to see it as falling in love with specific, pleasurable sensations (or the means to prevent pain)" (Bejerot, 1980, p. 253). Castellani, Wedgeworth, Wooton & Rugle (1997) hypothesised a bidirectional relationship between psychological stress, sociological structure and substance relapse, and argued that the way an individual copes with these various stressors moderates this relationship. Thus, treatment cannot focus solely on the substance abuse, psychological distress or social instability; it should rather view these variables as bi-directional – interacting and reinforcing each other.

Dodes (1996) offers a broad summary of various psychoanalytic conceptualisations of drug dependence. Dependence has been interpreted in a number of ways: as being a substitute for certain gratifications that the user would like to receive; as helping the user manage intolerable affects (especially helplessness and powerlessness); as an object substitute; to make up for ego-deficits in self care; to recreate a controllable suffering; to activate the 'all-good' self; as a substitute for a defect in psychological structure caused by an inadequate idealised self object; to restore a failed grandiose self or an idealised object; or used to defy a punitive superego and support an identity free from it.

Hofler & Kooyman (1996) draw on John Bowlby's theory of childhood attachment. Attachment theory proposes that infants are evolutionarily primed to form close relationships with early parental figures, and that the nature of a child's early relationship with his/her primary caregiver is an important predictor of the child's future personality development (Hardy, 2007). According to Hofler & Kooyman (1996) a number of studies suggest that the family life of drug dependent persons is often characterised by a fair amount of dysfunction (such as verbal, physical or sexual abuse, and alcoholic parents). The authors hypothesise therefore that individuals who are drug dependent have not formed close attachments with primary caregivers as these caregivers were unavailable to them. Thus, Hofler & Kooyman (1996) conclude that

> Addiction can be understood, on the background of the concepts of attachment theory and research, as a shift of the painful urge for physical closeness toward a "neutral object," the drug, which is cast to serve as a "secure base." The addicted person thus becomes able to withdraw from close relationships and intimacy. Pharmacological action of the drug enhances the shift toward a compulsive behaviour, both serving as relief from a long-known discomfort or painful experience (p. 518).

In line with psychoanalytic thinking, Khantzian (1985) proposes a self-medicating hypothesis – that drug dependent individuals are predisposed to dependence as they suffer with painful affective states. He argues that these individuals do not randomly select drugs, but that the selected drug "is the result of an interaction between the psychopharmacologic action of the drug and the dominant painful feelings with which they struggle" (Khantzian, 1985, p. 1259). He argues that opiate dependent persons choose heroin because of its ability to silence the threatening

emotions of rage and aggression. In contrast, cocaine dependent persons choose this drug because it relieves distress which is often associated with depression, hypomania and hyperactivity. He therefore theorises that individuals use specific drugs because of their self-medicating action. In line with this thinking is the hypothesis that the drug dependent person is not actually addicted to the drug, but rather to the experience which the drug gives him/her – "it is, in fact, the experience of having pain relieved to which the individual becomes addicted" (Peele, 1980, p. 143).

From a cognitive perspective, addictive behaviours arise out of a number of cognitive distortions and irrational beliefs. For Wanigaratne (2006), "An individual's core beliefs, or core schemas, are activated by a critical incident, which gives rise to anticipatory beliefs related to addiction, which in turn give rise to cravings" (p. 456). These cravings then activate beliefs which permit the individual to indulge in the drug habit, and this leads to the dependent behaviour. The Cognitive-Behavioural model of the relapse process (Marlatt & George, 1984) is perhaps the most recognized and established model. This model focuses on the interplay between behaviour and belief systems. In the likely event of encountering a high risk situation, the chance of relapse depends on the expectations of the individual, which include efficacy expectations (how confident they are to resist temptation) and outcome expectations (which refers to their beliefs about the consequences of giving in to the temptation) (Drummond, 2001). One of the key principles that emerged from this model was a phenomenon that has been called the Abstinence Violation Effect (Marlatt & George, 1984), which has already been discussed in section 2.3 of this literature review. The Relapse Prevention programme arose from this model, and it combines behavioural skills training with cognitive intervention techniques.

Biological theories that fall within this category emphasise the role of the neurotransmitter, dopamine, and its role in the reward and reinforcement pathways of the brain. Hence the results of long-term neuroadaptations in these reward systems result in persistent drug seeking and craving even after long periods of abstinence (Betz, Mihalic, Pinto, & Raffa, 2000). Volkow & Fowler (2000) propose that these reward circuits (involving the nucleus accumbens and amygdala) may be crucial in initiating drug self-administration, but that the actual state of addiction

"involves disruption of circuits involved in compulsive behaviours and with drive" (p. 318). These authors claim that imaging studies conducted on drug dependent individuals who are in withdrawal show clear indications that the orbitofrontal cortex is hypoactive. When these addicts are tested shortly after their last cocaine use or during their drug-induced craving, the orbitofrontal cortex is hypermetabolic. They argue that because the orbitofrontal cortex is involved with drive and compulsive repetitive behaviours, "its abnormal activation in the addicted subject could explain why compulsive drug self-administration occurs even with tolerance to the pleasurable drug effects and in the presence of adverse reactions" (Volkow & Fowler, 2000, p. 318).

In summary, this first group of theories attempts "to provide broad insights into the conceptualization of addiction. Thus addiction may be construed in terms of biological, social or psychological processes or some combination of these" (West, 2001, p. 3).

2.5.2 Theories that focus on effects of addictive stimuli

The second group of theories aims to explicate why certain stimuli have such a high propensity to becoming a focus for addiction. It is thought that the amount of pleasure, relief or excitement offered by the drugs may enhance their addictive potential. Additionally, these theories propose that drugs change the drug user which results in their effects being enhanced or relied upon, further enhancing their addictive potential (West, 2001). A dominant theme within this group of theories are the positive and negative reinforcing properties of drugs.

There are numerous classical conditioning theories of addiction and relapse, and Drummond (2001) provides a good summary of these theories. Childress, McLellan, Ehrman, & O' Brien (1988) discuss how classically conditioned responses in opioid and cocaine dependent persons can play a role in withdrawal and ultimately relapse. A drug dependent individual becomes conditioned to associate many substance-related cues to the experience of 'getting high'. After treatment, these cues can trigger what has been called 'cue reactivity' cravings (Drummond, 2001). These cravings can be initiated by three forms of cues, namely autonomic (e.g. increased skin conductance, heart rate, salivation), cognitive–symbolic (e.g. subjective craving)

or behavioural (e.g. drug seeking behaviour) (Drummond, 2001). Weinstein, Wilson, Bailey, Myles & Nutt (1997) recapitulate that “The cue exposure paradigm provided evidence that exposure of addicts to items or images associated with their drug-use may induce a state of conditioned craving to drug use” (p. 25).

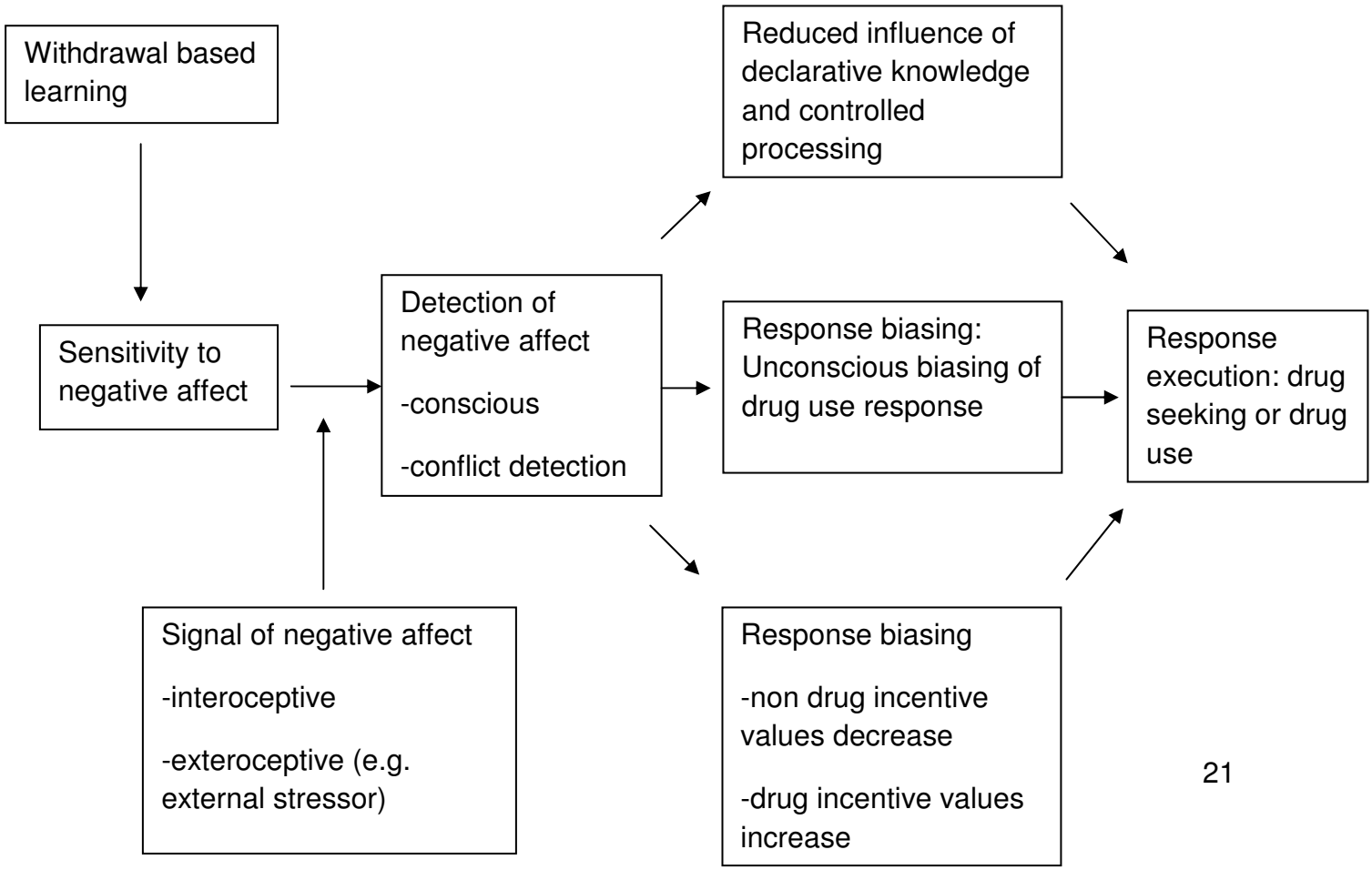
Opponent process theory (originally conceptualised by Richard Solomon and John Corbit) is a theory that focuses on motivational processes involved in addiction. Koob, Caine, Parsons, Markou, & Weiss (1997) provide a crisp outline of the theory. Its basic premise is that both pleasant and unpleasant affective states are opposed by centrally mediated mechanisms which aim to decrease the intensity of these states. Positive reinforces (like drugs) lead to positive hedonistic processes (which are simple and stable and follow administration of the drug). These positive hedonistic processes are opposed by negative hedonistic processes (which are of longer latency, slower to build up strength, and slower to decay). The pleasure and excitement that follows a cocaine high is thought to be a positive hedonistic process; the negative mood state when the drug is wearing off or during abstinence is presumably the negative hedonistic process.

Koob et al. (1997) cite a number of studies which indicate that rats injected with dopamine antagonists (neurochemicals which block dopamine receptor sites) show increased cocaine self-administration. As mentioned earlier, dopamine is directly involved with the reward system of the brain; hence blocking these receptor sites will lead to a decrease in experiential pleasure and the associated increase in self-administration. Essentially, the theory proposes that maintenance of drug use is a result of both negative and positive reinforcement processes. Abstinence results in a negative emotional state. “This aversive motivational state is a dysregulator of motivational homeostasis and thus provides a mechanism for a negative reinforcement process wherein the organism is administering the drug to alleviate the aversive state” (Koob et al., 1997, p. 519).

A similar model is proposed by Baker, Piper, McCarthy, Majeskie & Fiore (2004). Their theory argues that negative affect is the original setting for drug use and relapse. “It becomes so because of the regularity with which withdrawal occurs following discontinuation of drug use and the rapidity and efficiency with which drug

use ameliorates the aversive withdrawal syndrome" (Baker et al., 2004, p. 34). Different drugs produce different withdrawal symptoms; however negative affect is a universal element to withdrawal and research suggests that it is actually the motivationally prepotent element i.e. avoiding negative affect is the superior motivator for addictive drug use. Baker et al. (2004) propose that individuals learn to internally monitor these negative affects which occur when drug levels begin to fall in the body; the response to this is self administration of the drug. "Therefore, during ongoing drug administration, the individual may be aware of wanting to take drugs and may be aware of the act of drug self-administration, but he or she is typically unaware of the motivational impetus" (Baker et al., 2004, p. 35).

However, when this process is not effective enough, negative affect continues to increase and enters the individual's consciousness, affecting information processing (termed 'hot information processing'). This results in the individual paying less attention to 'cool information processing', which "prevents cognitive control resources from being applied to the process of affective coping and regulation" (Baker et al., 2004, p. 35). The model below is adapted from Baker et al. (2004) and reflects the drug motivational processing at high levels of affect.



The final theory that will be explored in this group is that of Robinson & Berridge (2001). They attempted to answer the question of why drug dependent persons compulsively seek drugs, and proposed the concept of 'incentive-sensitization'. This concept is based on four points, namely (1) that addictive drugs have the ability to produce long lasting neurological changes in the brain; (2) that the changed brain systems are normally involved in the process of incentive motivation and reward; (3) that these brain reward systems become particularly sensitive to drugs and drug associated stimuli (as a result of the addictive neuroadaptations); and (4) that "the brain systems that are sensitized do not mediate the pleasurable or euphoric effects of drugs (drug "liking"), but instead they mediate a subcomponent of reward we have called incentive salience or "wanting"" (Robinson & Berridge, 2001, p. 104). In essence, the individual may have begun using drugs because of 'liking' them, but as their addiction progresses, it becomes more about 'wanting' the drug.

2.5.3 Theories that focus on individual susceptibility

The next group of theories explores ideas relating to the particular vulnerability of certain individuals to addiction i.e. why are certain people more susceptible to addiction than others? Those that are more susceptible are therefore more at risk. As West (2001) notes, there seems to be a dominant theme of genetic susceptibility to a number of these theories.

Hiroi & Agatsuma (2005) commence by noting that there are a large number of individuals who experiment with drugs, but this experimentation does not always lead to dependence. They postulate therefore that there seems to be a genetic component to substance dependence, and cite a number of studies that suggest clear indications of the heritability of substance dependence in mice. Based on this research (albeit on mice and not humans) they hypothesise two models of addiction. In the first model, use of a substance results in plastic alterations in the brains of these individuals. It is this plasticity which is thought to result in addiction, and it is proposed that "specific genes might influence the rate of plasticity, thereby affecting the vulnerability to addiction" (Hiroi & Agatsuma, 2005, p. 340). In the second model, the onset and development of dependence is partially determined by genetic susceptibility (and environmental factors). It does not deny that neural plasticity leads

to addiction, but rather supposes that the rate of plasticity is influenced by genetic factors. Genetic variations “might prewire a brain so that a few exposures to a substance are sufficient for the development of addiction and dependence without plastic alterations” (Hiroi & Agatsuma, 2005, p. 340).

Although limited in sample size, Grant, Contoreggi, & London’s (2000) study provides a foundation for understanding the neuropsychology of addiction. The study assessed a critical aspect of addictive behaviour, namely the persistence of a positively rewarded behaviour despite adverse consequences. The authors used an assessment called The Gambling Task, which tests the ability to balance immediate rewards against long term negative consequences, and was originally developed to identify patients with frontal brain lesions. In their conclusion, they hypothesise that there may possibly be damage to the ventromedial prefrontal cortex of the brain in substance abusers, although whether this damage happened before or after drug addiction was not described. Grant et al. (2000) also note that when compared to normal controls, drug abusers have smaller volumes of grey matter in the pre-frontal lobe, and display differences in metabolic activity in the ventromedial prefrontal cortex.

2.5.4 Theories that focus on environmental factors

These theories aim to identify the social and environmental factors which possibly contribute to addiction (West, 2001). They address broader socio-environmental systems, as well as family systems and social roles, and stress the importance of broader systems which interact with the individual system; they therefore need to be foregrounded in this research report due to the systemic orientation of the report.

Richman & Dunham (1976) developed a theory with the aim of identifying the social factors that are associated with the spread of heroin addiction. They cite a number of studies which emphasise the relationship between social problem environments and increased geographic concentrations of opiate dependent persons. However, they point out that these studies only include epidemiological statistics, and do not assess the factors that lead to onset of drug addiction. In response to this gap, they composed a theory which assumed that “the transition to heroin use is a conversion-type phenomenon which is facilitated by the basic belief system, the network of

social circles and the social and psychological inducements for compliance" (Richman & Dunham, 1976, p. 383).

Socio-environmental impoverishment is said to produce biochemical and morphological changes in the brain which could be the basis for drug addiction. DeFeudis (1978) proposed that "psychotropic drugs are used to treat the symptoms produced by environmental impoverishment" (p. 303). These symptoms include depression, social isolation, despair and boredom. The theory is based on experiments undertaken with two groups of mice – isolated and group reared. The isolated group showed more susceptibility to chronic ethanol treatment, and were more sensitive to both morphine-induced analgesia and acutely-induced analgesia. It was assumed that these effects may be a related to the increased arousal response observed in isolated mice.

Stanton (1980) developed what is called a family homeostatic model of addiction. It is based on the assumption that families move through different stages in their life cycle. At each stage, a number of important transition points need to be accomplished (which can be stressful for families). Families who do not accomplish these transition points can become 'stuck' which results in problems and ultimately, a symptomatic family emerges. Stanton (1980) asserts that mounting data reveals that drug abusers originate in family environments where there was a premature loss or separation. The resulting fear of separation causes the drug dependent individual to be overly dependent on the family. When they begin to achieve some independence, and are heading towards leaving the family, what develops is a family crisis. This results in the drug dependent person resorting to some kind of failure behaviour and the family problem dissolves. Therefore this theory does seem to offer a reason why relapse rates are so high in substance abusers.

Correspondingly, Beavers & Hampson (1993) have proposed a model of clinical and well functioning families. Their model is known as the Beavers Systems Model and it identifies nine different types of family groupings. They propose that individuals with substance abuse problems are likely to emerge from mid-range centrifugal families. These families believe that control will best be achieved by using intimidation and authority; however these families do not expect their efforts at control to be

successful. This lack of control is dealt with by hostility, attack and blame, and expressions of warmth and tenderness are felt to be anxiety provoking. The parental couple relationship is characterised by open hostility and unresolved power issues. Children move out onto the streets earlier than the norm, and have difficulty with authority figures. Psychiatric illnesses generally manifest as acting out behaviour disorders such as substance abuse, conduct disorder etc.

Finally, Hajema & Knibbe (1998) suggested that changes in marital status, employment status and having children would have an effect on the frequency of heavy drinking[3]. The hypothesis was grounded in role theory and the authors assumed that "a shift into more social roles would decrease consumption and heavy drinking while the shift away from social roles would be associated with an increase in consumption and heavy drinking" (Hajema & Knibbe, 1998, p. 1717). Their research hypothesis was partially confirmed – gaining a spouse or parental role was associated with a reduction in alcohol consumption; no reduction was found when gaining a new employment role. With the exception of losing the spouse role for women as being associated with an increase in heavy drinking, it was generally concluded that losing roles did not lead to an increased consumption of alcohol.

2.5.5 Theories that focus on recovery and relapse

This final group of theories includes those that focus on recovery from addiction and relapse. As protective factors in preventing relapse forms the main area for this research, the researcher presents a more detailed discussion of the various models and theories that make up this section.

Finney & Moos (1995) developed a model in an attempt to identify those factors which facilitated or hindered entering treatment for alcohol abuse. Their model is called the Stress and Coping Model and views treatment entry "as a response employed after other resources and responses have failed to alleviate a stressful situation" (Finney & Moos, 1995, p. 1224). The model is composed of three broad

[3] While there are most definitely variations between alcohol, cocaine and heroin users, an underlying dynamic of dependence is universal; hence it is argued that theories that have been constructed around different types of substances should be somewhat inter-changeable.

factors which influence treatment entry, namely (1) the impetus to seek treatment, (2) counteractive factors, and (3) facilitative factors.

There are three factors that create an impetus to seek treatment. Firstly, people experiencing hardship or distress are more likely to seek treatment. Their perception of the severity of their problem affected the likelihood of treatment entry, as well as the unfavorable consequences that had resulted from their drinking In addition, psychological distress such as depression, psychiatric symptoms, and low sense of self esteem affected treatment entry. Secondly, stressors had an influence on impetus to seek treatment. These stressors refer to negative life events (which may or not be related to their addiction) and stressors in multiple life domains (such as job and health domains). The third factor that has an effect on an individual's impetus to seek treatment is the social pressure exerted on the individual to enter treatment.

Counteractive factors which hinder the impetus to seek treatment include social resources, affect regulation coping, and perceived ineffectiveness of treatment. In terms of social resources, the model assumes that people who have more social resources (who are married, employed, have more financial resources, higher incomes, and experience more support) are less likely to enter treatment. Coping strategies of individuals more likely to enter treatment are affective-focused ("I told myself things would get better") rather than problem-focused (actively addressing the problem). Finally, and somewhat obviously, "people who perceived treatment as less effective would be less likely to enter treatment" (Finney & Moos, 1995, p. 1226).

The third broad factors are grouped under facilitative factors. The model proposes that these factors will lead an individual to seek treatment and include whether or not the individual has previously sought treatment for the problem from non-formal sources (such as Alcoholics Anonymous, physicians, or religious counselors), whether the individual has been referred for treatment, and whether the individual is able to go into a treatment programme immediately after detoxification.

Fisher, Elias & Ritz (1998) assessed 108 patients in an inpatient treatment facility, and tracked their progress for a year after being discharged from the facility. The authors aimed to identify personality traits that were related to a return to heavy drinking or drug use. The study was based on the 5-factor model of personality, and

was assessed using the NEO Personality Inventory. It proposes five broad personality dimensions, namely neuroticism, extroversion, openness, agreeableness, and conscientiousness. As was hypothesised by the authors, those individuals who relapsed scored high on the neuroticism dimension, and low on the conscientiousness dimension, in comparison to the normative sample. “The dimension of neuroticism involves the degree to which individuals are susceptible to experiencing negative emotions” (Fisher et al., 1998, p. 1041) and it has been noted that negative emotions play a role in relapse behaviours. The conscientiousness dimension “relates to the level of motivation, organization, and persistence required for success in goal-directed behaviour” (Fisher et al., 1998, p. 1041). Clearly, if one is going to prevent relapse, the individual will need to plan ahead to avoid high-risk situations. Hence it is logical that those individuals who relapse would score lower on the conscientiousness dimension.

The treatment implications of these results suggest that when individuals present in treatment facilities with high levels of emotional instability, their treatment programmes need to be adjusted accordingly or even intensified. In addition, instead of labeling these patients as ‘noncompliant’ because they do not follow through with treatment plans, “treatment teams may need to recognize that these patients lack the persistence, organization, and motivation that is required to be successful in goal-directed behaviours, such as setting up a plan to prevent relapse” (Fisher et al., 1998, p.1046). As a result of this, these patients may need to rely more on staff to provide increased levels of structure and support in order to reach their treatment goals.

Miller (1991) summarises the neuropsychological, personality, and cognitive styles that have been found to play a role in predicting either relapse or recovery in alcoholics and drug dependent individuals. In terms of neuropsychological characteristics, it has been found that those individuals who relapse show poor outcomes on measures of language, abstract reasoning, planning, and cognitive flexibility. Their personality profiles are characterised by impulsivity, antisocial personality styles, and affective disorders. Cognitive style refers to “the individual pattern of intellectual, perceptual, and interpretive processes which affects how a given person views the world and regulates his or her behaviour” (Miller, 1991, p.

277). Those individuals who relapse show a cognitive style that is non-reflective and impulsive, and this "relates to an inability to use inner speech and other verbal self-regulatory mechanisms to evaluate, plan, and guide behaviour" (Miller, 1991, p. 278).

The concluding call (as in Fisher et al., 1998) is for a dynamic treatment programme that caters for different individuals – less structured, more flexible and self-directed forms of treatment should be used for those better functioning individuals (i.e. who have sufficient ego autonomy, are capable of self reflection, have a future orientation, have a high level of frustration tolerance, have good communication skills, and an internal locus of control) whereas more tightly structured and externally supportive treatment programmes should be used with lower functioning individuals (i.e. who are impulsive, cognitively deficient, and have poor internal resources) (Miller, 1991).

Using an animal model of relapse, Stewart (2000) identified a number of pathways that cause rats to recommence drug self-administration. After training rats to self-administer heroin or cocaine by pressing a lever, a period of extinction takes place where no drug is administered to the rat when the response is performed. The researcher then executed a number of experiments in order to identify events that would most likely cause the rat to begin self-administration of the drug again. Stewart (2000) found that the three most effective events for reinstating drug use behaviour were exposure to environmental stimuli associated with the drug, re-exposure to the drug again, and brief exposure to a period of stress. The most powerful event was the re-exposure to the particular drug.

Probably the most influential model of relapse was Marlatt & George's Relapse Prevention Treatment Model (1984), which has already been briefly discussed. What has emerged from the model is a relapse prevention programme which is predominantly psychoeducational, combining both behavioural skill training programmes and cognitive intervention techniques.

The model begins with the assumption that the individual who maintains abstinence experiences a certain amount of control. Naturally, the longer the individual maintains abstinence, the greater this perception of control. This perception

continues until the person encounters a high risk situation, which is defined as “any situation which poses a threat to the individual’s sense of control and increases the risk of potential relapse” (Marlatt & George, 1984, p. 264).

Three primary high risk situations have been identified by the model, including negative emotional states, interpersonal conflict, and social pressure. Negative emotional states refer to situations where the individual experiences an unpleasant mood (frustration, anger, anxiety, depression, or boredom). In their research, these negative mood states accounted for 35 percent of all relapses. Secondly, interpersonal conflict (which accounted for 16 percent of all relapses) refers to situations where the individual has experienced a recent or ongoing conflict in an interpersonal relationship (such as in a marriage, friendship, family member, etc.). The third high risk situation is social pressure, and accounted for 20 percent of all relapses in their study. It refers to situations where another person or group pressurizes the individual to engage in the proscribed behaviour.

What mediates the effects of the high risk situation is whether or not the individual is able to employ effective coping skills. If they are able to cope successfully in the situation, then they experience a sense of mastery or perception of control. This often leads the individual to think that they will be able to master all similar situations, and increases levels of the individual’s sense of self-efficacy. “As the duration of the abstinence (or period of controlled use) increases and the individual is able to cope effectively with more and more high risk situations, perception of control increases in a cumulative fashion. The probability of relapse decreases accordingly” (Marlatt & George, 1984, p. 265).

If the individual is unable to employ effective coping responses, they experience a decrease in their perceptions of control, and an associated decrease in self-efficacy, as well as a sense of hopelessness. In addition, if they hold positive expectancies about the effects of the drug (i.e. they anticipate immediate positive effects), and ignore the delayed negative consequences, then the probability of relapse in enhanced.

Marlatt & George (1984) refer to a phenomenon known as the AVE – Abstinence Violation Effect. They argue that most people believe in an absolute dictum – either

you are in active addiction, or you are abstinent. Thus there is no flexibility for a middle-of-the-road approach. The AVE is likely to occur when an individual who was previously committed to abstinence experiences a lapse. The intensity of the AVE will vary according to "the degree of prior commitment or effort expended to maintain abstinence, the duration of the abstinence period (the longer the period, the greater the effect), and the subjective value or importance of the prohibited behaviour to the individual" (Marlatt & George, 1984, p. 265). The AVE is characterised by two important cognitive-affective elements namely cognitive dissonance (conflict and guilt) and a personal attribution effect (blaming one's self as the cause of the relapse). The severity of the AVE increases the risk for a full relapse.

Thus, a number of predictive factors of a relapse can be identified from the aforementioned theories. These factors include stressful life and job situations, social pressure, experiencing high degrees of negative emotional states and low levels of organization, motivation and perseverance. In addition, poor cognitive flexibility, a non-reflective and impulsive cognitive style, and an inability to use inner speech to moderate behaviour were identified. Finally, being exposed to both the environmental stimuli associated with the drug as well as the drug itself can also lead to relapse. It would seem logical to conclude that merely inverting these factors could have the opposite effect of a relapse, viz. abstinence.

As will be elaborated further in chapter four, it can be argued that a number of these factors were identified in the interviews with the participants. For example, while many of the participants cite situations of stress as being the moment in their recovery when they had considered re-using, it is clear that they employed a number of coping mechanisms to avoid the relapse (such as cognitive rehearsal – "I must avoid dangerous people, places and things"). This resulted in diminished levels of impulsivity, and hence, protected the participant from experiencing a relapse.

With these theories of addiction and relapse in mind, the researcher now presents an overview of systems theory (which to some degree has informed a number of the theories already discussed). What is clearly apparent from a review of the literature is that no one system can be isolated to predict vulnerability to addiction and relapse.

Instead, biological, psychological, and environmental factors interact, with the specific combination possibly resulting in addiction and relapse.

2.6 Systems theory

The theoretical point of departure for this research is the well-known framework of systems theory. A brief introduction and overview of general systems theory now follows.

Systems theory was originally conceptualised in the 1940s by Van Bertalanffy (Provis, 1992), and it has become a well established framework. Its basic assumption is that nothing can be considered as an isolated entity; it is always a part of a larger system. This system is always more than the sum of its parts (Hanson, 1995; Spronck & Compernolle, 1997). Systemic thinking has drawn many of its ideas from biological and ecological systems (such as concepts like homeostasis, positive and negative feedback, and dynamic equilibrium).

Under a systems theory approach, no behaviour can be clearly interpreted and understood without considering the particular context of that behaviour. This is the one of the foundational premises of the theory. Accordingly, “behaviours are embedded in inextricably linked contexts, such that their particular nature may be knowable only within their native context” (Hanson, 1995, p. 20). Implicit within this idea of context, is the concept of nonsummativity (the whole is greater than the sum of its parts), initially described by Aristotle. In short, if each element in a particular system is analysed individually, the characteristics that they display will be less than what they would display when considered together, as interacting with the other elements in the system. When considering substance abuse, abstinence and relapse behaviour, one cannot therefore consider the behaviour in isolation. The reason for this is that the behaviour emerged within a particular context; to ignore the context would lead to a misinterpretation of the behaviour. Systems theory would possibly offer the following critique of rehabilitation principles: How can we remove the drug dependent person from their natural system, treat them in a new, unnatural system and then reintroduce them into their old system and expect them to maintain abstinence?

Miller (1978, as cited in Spronck & Compernolle, 1997) defines a system as

> a set of interacting units with relationships among them. The word "set" implies that the units have some common properties. These common properties are essential if the units are to interact or have relationships. The state of each unit is constrained by, conditioned by, or dependent on the state of other units. The units are coupled. Moreover, there is at least one measure of the sum of its units which is larger than the sum of that measure of its units (p. 152).

Like all interconnected systems, change in one part of the system will lead to a change in another part, which will lead to change in another part and so forth. In systemic terms, this is referred to as a system being in a state of dynamic equilibrium. Dynamic equilibrium implies that systems strive to maintain homeostasis, or balance. Cybernetics is the concept used to describe this maintenance of balance, and it "suggests that all change can be understood as the effort to maintain some constancy and all constancy is maintained through change" (Vorster, 2003, p. 22). In other words, cybernetics ensures that the system steers itself through the use of feedback. "Feedback refers to the ability of a system to reintroduce output as input" (Hanson, 1995, p. 58), and can either be positive feedback or negative feedback. Hanson (1995) differentiates between the two types of feedback as follows: "Positive feedback refers to a feedback process where there is change. Negative feedback refers to a feedback process where there is no change" (p. 60). Negative feedback therefore maintains the systems homeostasis. He further notes that "by focusing on the negative and positive feedback processes in a system, it is possible to trace the roots of problems" (p. 61)[4].

Another key systems theory concept is equifinality. "Equifinality captures the idea that when you act on a system, a number of different stimuli can lead to the same result" (Hanson, 1995, p. 64). The alternative view is a multifinality viewpoint, which implies that a single stimulus can produce multiple results.

[4] A rudimentary example may help describe this cybernetic, self-regulating process. An adolescent in a family system has turned to drugs to cope with the emotional turmoil of his constantly arguing parents. The parents become aware of the addiction, and instead of changing their behaviour, their sons' addiction problem results in them arguing more. This reinforces the pattern of abuse by the adolescent and would be an example of negative feedback, since no change took place in the system. However, if the parents realised the impact of their arguing on the adolescent and made a significant effort to change this behaviour, it may result in the adolescent decreasing or stopping his substance abuse behaviour. This would be an example of positive feedback, since there was a change made in the system.

Thus, the positivistic idea of a linear, single 'cause-effect' relationship is called into question by systems theory. Instead, "any action or inaction will reverberate through the entire system leading to unpredictable effects and sometimes effects that are precisely the inverse of the intended effect" (Hanson, 1995, p. 27).

Based on this knowledge of systemic theory, it is logical to conclude that attributing primary causation at the individual level for a particular behaviour is impossible. This is because allocating blame ignores a central component of systems theory, that of nonsummativity. "The notion of blame involves separating parts of a system in order to isolate the causal factor and then attributing responsibility to that factor" (Hanson, 1995, p. 51). Separating parts of the system to analyse them separately, as well as the implicit idea of linear causality, is inconsistent with a systemic view, and therefore ensures that blame for a specific behaviour is allocated to the entire system, and not just an individual. This is supported by Provis (1992), who affirms that "the problem does not lie with the individual. The problem belongs to the system" (p. 26).

With regards to systems theory and relapse, "one has to contemplate whether a relapse constitutes total failure, implying the end of the road, or could it be a part of a process for the individual or the system attempting change" (Janse van Rensburg, 1998, p. 54). In other words, the relapse may be the system trying to restore balance, or it may signify the breakdown of the system entirely. Additionally, the system could adjust to the new elements introduced during the treatment phase, maintain the change, and the individual could go on to live in recovery and abstinence.

To conclude this section, Hanson (1995) wisely notes that "in terms of everyday relevance, a systems notion allows thinking in sequence and with it resistance of simple short-term solutions to complex systemic problems" (p. 31). This means that according to systemic thinking, the solution to the relapse problem is not short term, but is diverse, complex, and non-linear.

2.7 Substance abuse, abstinence and relapse

A relatively sizeable body of literature examines the processes and experiences involved in a users relapse to and recovery from drugs.

A study that focused on 1326 adult users in Chicago was conducted by Scott et al. (2005), and their major research goal was to identify the pathways in the treatment, relapse, and recovery cycle over three years. While the drugs of choice of the participants varied, approximately 35 percent of the sample identified cocaine as their primary drug, and 31 percent identified heroin as their primary drug of choice. Six factors that predicted the pathway from relapse to abstinence were identified.

> Relative to those who continued using, individuals who made the transition to abstinence: (a) were older when they first used drugs or alcohol to intoxication, (b) reported fewer symptoms of mental distress, (c) had fewer legal problems, (d) were more likely to be homeless, (e) had more non-using friends, and (f) spent more time in treatment during the follow up period (Scott et al., 2005, p. S67-S68).

Gossop et al. (2002) focused on the factors associated with abstinence, lapse, and relapse in heroin patients, specifically examining the coping responses that were employed. A pretest-posttest design was used, and the target population was assessed using a questionnaire. They reported that the clients who remained abstinent used three sets of coping responses more frequently (avoidance, cognitive, and distraction) than those clients who relapsed. Items that fell within avoidance coping included the removal of past reminders of their drug lifestyle, cutting off ties with friends from that lifestyle, and remaining with people who support their sobriety. Cognitive coping items were based on positive affirmation of themselves, such as 'I can choose not to use drugs' and 'I do not need to use drugs to be content with myself'. The third category, distraction, included the use of physical activity, relaxation techniques, and thought changes.

Gossop et al. (2002) concluded that

> [T]he clients in the abstinent group reported making greater use of all three types of coping responses than at intake, and their increased use of coping responses was significantly different to that of the clients who had used heroin after treatment. The abstinent group also reported making more use of avoidance and distraction of coping responses at follow-up than the lapse and relapse groups (p. 1263).

Heroin abstinence and relapse was also investigated in the study conducted by Llorente del Pozo et al. (1998). Their results indicate a number of differences between these two groups. Alcohol was associated with initiating cravings in the

abstinent group, and was strongly associated with actual relapse in the relapse group. The main justification for craving used by those that remained abstinent was to escape from personal problems. Justification for heroin consumption by the relapsed group was due to a lack of satisfaction with abstinence. In their conclusion, Llorente del Pozo et al. (1998) note that

> abstinent subjects are distinguished from relapsed ones because they made more frequent use of some change processes such as re-evaluation of their attitude to abstinence and learning alternative solutions to consumption (self-evaluation and self liberation) and re-evaluation of their personal situations and the role of society and their families (social liberation), together with self-reinforcement because of success and the anticipation of positive consequences of abstinence (handling of contingencies) (p. 167).

In keeping with systems theory, as well as the assumption that the home setting has an influence on relapse and abstinence, an understanding of the family system of drug users is vital.

A study conducted by Velleman, Bennett, Miller, Orford, Rigby & Tod (1993) explored the families of problem drug users (drugs of choice included opiates, amphetamines, tranquilizers and a combination of drugs). Family members were exposed to physical violence (50%), unpredictable behaviour (42%), stealing (42%), lethargy (26%) and embarrassing behaviour in front of others (38%). The results from the enquiry suggest "that relatives find coping with a drug abuser in the family very difficult; and that they do not simply choose an optimal way of dealing with this, but that they oscillate from one method to another, seeking often desperately for some ideal solution" (Velleman et al., 1993, p. 1288).

The parents' experience of drug users who were dependent on heroin has also been researched (Butler & Bauld, 2005). The researchers pointed out that the rehabilitation process often neglects the parents. Numerous benefits were identified for the parents when they were involved in the rehabilitation process. "These included a reduced sense of isolation, an increased knowledge of drugs and drug-related issues, and a greater empathy for their son or daughter. This resulted in an improved support network for the drug user" (Butler & Bauld, 2005, p. 35). Additionally, it was found in a study conducted by McMahon (2001) that perceived social support was initially low for those individuals that were able to remain

abstinent, but that their perceived level of social support significantly increased after being discharged from treatment.

Based on the rehabilitation principle of changing lifestyle factors (such as friends and places), Walton et al. (1995) conducted a study to investigate the influence of social settings on addiction relapse in 96 participants. The dominant idea that relapse in these settings is due to exposure to the substance was invalidated. They found that "a person's perception of risk for relapse in a setting was the most potent construct in determining future relapse and that the home setting had a greater influence on relapse than the work or community settings" (p. 231).

A South African study that focused on relapsed patients was conducted by Bain (2004). She conducted a qualitative study with eight individuals who relapsed at a treatment facility in Auckland Park, Johannesburg. Using thematic content analysis, she isolated six primary themes from her interviews.

A large portion of the interviewee's accounts of their relapse experience mentioned themes of *control and powerlessness*. Generally, a period of healthy living would be the norm for a while, and then something would happen around the interviewee that made them feel overwhelmed. "The use of substances initially seems to offer them the promise of control, but eventually also becomes 'out of control', leaving the users more powerless than ever" (Bain, 2004, p. 100). The second theme of *trust* was consistent across all the interviews, and it "recurred throughout all the interviews in terms of trust in themselves, their trust in others, other's trust in them and trust in God" (Bain, 2004, p. 107). *Splitting,* the third theme that Bain (2004) described was identified by how they regularly spoke about 'The Addict Within', suggesting a fragmented identity that was not seen as part of their personality.

Fourthly, *denial* was a strong theme that arose from the transcript analysis. Denial of external reality takes place when the user thinks that no one around them knows about their addiction, even if it is obvious to everyone. The fifth theme of *detachment* that Bain (2004) described was displayed by the way the interviewees maintained superficial relationships with friends and family members. Finally, *loneliness*, the most common theme, proposes that these users have no close relationships, even though these relationships are desired. A sense of desertion is also implied.

Secondary feelings that were included in this theme were feelings of abandonment and rejection. Many of the interviewees had at least one parent who was emotionally 'unavailable', and Bain (2004) suggested that this experience of their parents being unavailable most probably left them with feelings of abandonment. In addition, many of the interviewees expressed that they felt different to other people – a sense of 'not belonging'.

While the literature that has been cited is quite comprehensive, it does imply a gap, especially in South Africa, for a qualitative analysis of the experiences of persons who have recovered from drug dependence, as opposed to those individuals who relapse.

2.8 Conclusion

This chapter has provided a broad overview of the field of substance abuse, specifically focussing on relapse and recovery.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This section of the report will provide a summary of the research methods that were employed throughout the research process. A discussion and motivation for using the various methodologies is included in each section. This chapter begins with a delineation of the sampling procedure, as well as how the data was collected. A review of the data analysis procedure follows, and the chapter closes with a discussion around the issue of qualitative research and reflexivity.

3.2 Sampling and Data collection

The sample population included individuals who had been dependent on heroin and cocaine, had gone through a treatment process, and had remained abstinent thereafter. In order to be selected, the participants needed to have remained abstinent from their drug habit for the past 10 months. Six participants were recruited and were interviewed. By the sixth interview, the researcher was beginning to notice that the data being disclosed was reaching a saturation point, as not many new themes were arising. However, further interviews may have provided additional themes.

It was initially proposed that the researcher would obtain the full sample from Elim Clinic. The clinic was contacted and their permission was obtained after they had reviewed the research proposal. The researcher made his request for participants known at the weekly aftercare meeting. However, this did not result in the recruitment of a sufficient number of possible participants. Therefore, additional participants were located by word of mouth from various friends.

The sampling methodology employed in this research was a form of non-probability purposive sampling (Whitley, 2002). Non-probability or convenience samples consist of individuals from whom the researcher finds it suitable to collect data. These kinds of samples are generally easy to acquire, and due to the time limits placed on this research, it was assumed that this would be an apt sampling measure. The sampling was purposive as each individual was purposely chosen since they represented the particular interest for this research (Strydom & Delport, 2002).

Since purposive sampling in and of itself did not yield a sufficient sample size, snowball sampling was therefore employed to recruit the remaining participants. Once again, snowball sampling is a form of non-probability sampling, but it is directly aimed at locating individuals who are difficult to locate (Strydom & Delport, 2002). Once an individual is located who meets the criteria for the research, the individual is then requested to "nominate acquaintances whom they think might be willing to participate in the research" (Whitley, 2002, p. 395).

The semi structured interview format was utilised as it is the most widely used method of data collection in qualitative research since "the interview data can be analysed in a variety of ways, which means that semi-structured interviewing is a method of data collection that is compatible with several methods of data analysis" (Willig, 2001, p. 21). The semi structured interview was utilised as it allowed for the researcher to gain a detailed picture of the participant's perceptions and accounts of their process of recovery (Greef, 2002). Each interview was conducted in a venue that was convenient for both the researcher and the participant, and lasted for approximately one hour. Initially, an attempt was made to develop rapport with the participant before more personal questions were posed.

The interview then proceeded, and since the semi-structured interview format was being followed, data collection was therefore quite flexible and conversational (Whitley, 2002). While it is possible that some of the interviewees may have lied about certain experiences, or may have tried to present themselves in a positive manner, Craig (1987) has pointed out that "most of the research [concerning the reliability of drug dependent persons self-reports] has indicated a high degree of correspondence between life history information and data obtained from family, criminal records and other significant informants" (p. 15).

The interviews were conducted between June and July 2008, and all of the data was transcribed by the middle of August 2008. The semi-structured interviews showed some variations, but generally the researcher was able to ask all of the proposed questions. These questions were generally open ended, which allowed the participant to elaborate and expand on their own individual experiences. Questions that were asked revolved around their motivating factors for maintaining abstinence,

possible risky situations that they had encountered since treatment and how they had coped in these situations. Treatment, as well as social support related questions were also asked.

3.3 Transcription and Data analysis

In order for the data to be analysed appropriately, it was typed out into a Word document format. The transcribers made every effort to type the data out verbatim. Once the transcriptions were returned to the researcher, each interview was proof read in order to ensure that no sections of the data recordings had been left out of the transcription. While this was a laborious process, it was useful for the researcher as it inducted him into the data analysis process.

Thematic Content Analysis (TCA) was used to analyse the transcriptions. Braun & Clarke (2006) define thematic analysis as “a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic” (p. 79). By using this method for the analysis, one can make “objective and systematic inferences about theoretically relevant messages” (Dane, 1990, p. 170). This data analysis technique is consistent with a systems theory approach, since content analysis cannot be used to test causal relationships between variables (Berg, 1998; Chadwick, Bahr, & Albrecht, 1984). In addition, it is a flexible approach (Braun & Clarke, 2006) and is therefore consistent with the flexibility that was offered by using semi-structured interviews.

The particular form that this thematic content analysis followed will now be discussed. While the researcher acknowledges his own theoretical and epistemological background, an attempt was made to identify themes that were strongly linked to the data. However, since the literature review chapter had already been completed, it can be assumed that this may have led the data analysis at some points. Therefore, it would seem that a fair mix of inductive and deductive analysis took place (Braun & Clarke, 2006). In terms of the level at which the themes were identified, the thematic analysis focused on analysing semantic themes (themes were identified at the explicit or surface meanings of the data) (Braun & Clarke,

2006). The motivation for analysing the surface content of the themes is in line with the overarching goal of this research – to describe the process of recovery.

As the researcher has pointed out, there are no set rules to follow when conducting a thematic analysis. However, Braun & Clarke (2006) do propose some pragmatic guidelines to follow. They point out that "analysis is not a *linear* process of simply moving from one phase to the next. Instead, it is more of a *recursive* process, where movement is back and forth as needed throughout the phases" (Braun & Clarke, 2006, p. 86). Their proposed phases are as follows:

1. Familiarizing yourself with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing the themes
5. Defining and naming the themes
6. Producing the report.

A breakdown of the phases that were followed by the researcher now commences.

Phase One: Familiarizing yourself with the data

While transcription of the data by the researcher himself would have been a useful first step in familiarizing himself with the data, it was decided that due to time constraints, he would obtain external assistance for this phase of the research. Once the transcriptions were returned, the researcher read them while listening to the audio recordings in order to ensure no important information had been omitted. Thereafter, the researcher read and re-read the transcripts, thus immersing and familiarizing himself with the data. Boyatzis (1998) notes that by immersing oneself in the data, an attempt is made to internalize the data. However, the researcher did not simply read the transcripts in this phase; he actively sought meanings and patterns, which is recommended by Braun & Clarke (2006). Notes were taken and important aspects were highlighted.

Phase Two: Generating initial codes

This phase involved the production of the initial codes from each data set, and therefore involved a vertical analysis. A large number of codes were developed, and some data extracts were allocated more than one code. Boyatzis (1998) states that "The unit of coding is the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (p. 63). The process of coding assisted the researcher in organizing the data into meaningful groups. Each data set was coded individually, and codes were isolated and organized as can be seen in the example below:

QUOTE	CODE	PERSONAL REFLECTIONS
Page 4: "The treatment was fantastic…	Idolizing treatment facility	What purpose does this serve for the recovering individual since most of them felt that their treatment facility was the best?

Table 1: Data extract taken from Andre's interview

Phases Three, Four and Five: Searching, reviewing and naming the themes

Once the vertical analysis of each data set had been conducted, the researcher then conducted a horizontal analysis viz. an analysis across all six data sets in order to identify recurring and conflicting codes. Braun & Clarke (2006) note that this phase re-focuses the analysis at the broader level of themes. A theme is defined as "a pattern found in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon" (Boyatzis, 1998, p. 4). The codes were analysed and combined into overarching themes. This process felt somewhat overwhelming for the researcher, as pieces of paper with codes on were strewn all over the floor. He then grouped similar codes together and gave them a specific theme name. This process was reviewed by the researcher and his supervisor. Thereafter, a thematic map was constructed which appears in the discussion chapter of this research report. As noted by Braun & Clarke (2006), by the end of these phases the researcher had a really good idea of what his different themes were and how they fitted together to portray an integrated

account of the experience of recovery in persons previously dependent on cocaine or heroin.

Phase Six: Producing the report

The final phase involved the write-up of the analysis. Braun & Clarke (2006) emphasise the importance that the write-up provide "a concise, coherent, logical, non-repetitive and interesting account of the story the data tell… [and] must provide sufficient evidence of the themes within the data" (p. 93). The aim is to move beyond description of the data, to actually making an argument. Relevant literature that supported or that was contradictory to the thematic analysis write-up was also added, thereby infusing data analysis with discussion.

3.4 Qualitative research and reflexivity

I adopted a qualitative structure to this research because in qualitative research, "the researcher is an inseparable part of the research process; the researcher's experiences, not only those of the research participants, are valuable data" (Whitley, 2002, p. 34).

I feel that it would therefore be important at this point to make a cautionary note concerning my own subjectivity. To deny personal interest and claim objectivity in this field of study would be futile since I have had direct encounters with acquaintances who have relapsed. In addition, I acknowledge that I cannot be separated from either my research subjects nor their discussions on drugs as I form a part of the very system that I am attempting to analyze.

3.5 Conclusion

This chapter of the research report has provided a synopsis of the methods that were used, as well as a motivation for their particular usage. The sampling and data collection procedures were discussed. After a brief explanation of the process of transcription, a more detailed elucidation took place where the researcher spoke to the data analysis procedure.

CHAPTER FOUR: DISCUSSION

4.1 Introduction

This section of the research report will provide an in-depth discussion of the themes identified in the corpus yielded from the semi-structured interviews. A succinct initial section will provide the reader with an orientation to the background and history of the six participants, and thereafter, the main body of this chapter will highlight and discuss the predominant themes that were identified.

4.2 The participants in the study

There were six participants that were interviewed for this study. Two were sourced from the aftercare group of the Elim Drug and Alcohol Rehabilitation Centre. The remaining four participants were contacted by the researcher directly through a snow ball sampling method. All participants met the full inclusion criteria (see chapter three), and they were all interviewed over a six week period. All the names have been changed in order to ensure confidentiality.

Andre

The first interview conducted was with Andre. He is a single, 43 year old white male who works as a pricing analyst. Andre had been treated at an in-patient four week treatment programme and has not relapsed. His primary drug of choice was rocks (a crystalised form of cocaine) and he smoked it for two years. At the time of the interview, Andre had been abstinent and in recovery for 19 months.

Mark

Mark is a 31 year old single white male, and he was the second interviewee. He is a small business owner, whose primary drug of choice was heroin, which he snorted for three years. He was treated at an out-patient treatment facility and the duration of his treatment was seven weeks. He has not relapsed. At the time of the interview, Mark had been abstinent and in recovery for 16 months.

Brendon

The third interview was conducted with Brendon. He is a 40 year old white divorced male, who has three children. He works as a key accounts manager, and his primary drug of choice was heroin, which he administered through injection. The duration of his heroin usage was six months. Brendon was treated at a facility in Mozambique where he stayed for 11 months. He had received treatment before this at an in-patient facility. He has not relapsed since leaving the Mozambique treatment facility and at the time of the interview, he had been abstinent and in recovery for 22 months.

Tanya

The fourth interview was conducted with Tanya, who is a single, 38 year old white female. She works in sales and marketing for her family business, and has an 18-year old daughter. Her primary drug of choice was cocaine which she snorted for about seven years. Tanya entered an in-patient treatment facility where she was treated for four weeks. She has not relapsed and at the time of the interview, Tanya had been abstinent and in recovery for 28 months.

Lee

Lee is a 27 year old white female who is engaged to be married, and is currently completing a second degree in social work. Her primary drug of choice was cocaine which she snorted for four years. She was the fifth participant to be interviewed. Lee attended an 8 week outpatient treatment facility, and has not relapsed. At the time of the interview, Lee had been abstinent and in recovery for 26 months.

Elaine

The final interview was conducted with Elaine. She is a 27 year old white single female, who works as an addiction counsellor. Elaine's primary drug of choice was heroin which she smoked for seven years. She entered an out-patient treatment facility which she attended for 20 weeks. She has not relapsed and at the time of the interview, Elaine had been abstinent and in recovery for 48 months.

It should be noted that while the researcher has indicated each participant's primary drug of choice, there was a long history of abusing multiple substances in all participants, which included alcohol, ecstasy, CAT, LSD, and marijuana[5]. The following table provides a summary of the participants.

Name	Age	Sex	Drug of choice	Total clean time (months)	Type of treatment
Andre	43	Male	Rocks	19	In-patient
Mark	31	Male	Heroin	16	Out-patient
Brendon	40	Male	Heroin	22	In-patient
Tanya	38	Female	Cocaine	28	In-patient
Lee	27	Female	Cocaine	26	Out-patient
Elaine	27	Female	Heroin	48	Out-patient
Average	**34.3**			**26.5**	

Table 2: Summary of research participants

4.3. Context of the interviews

Two of the interviews were conducted at Elim Drug Clinic in one of the therapist's offices. Another interview was conducted at the participant's place of work. The remaining three interviews were conducted in the participant's homes. All interviews were carried out at a time that suited both the participant and the researcher.

4.4 A discussion and analysis of the interviews themes and subthemes.

The remainder of this chapter focuses on the discussion and analysis of the six interviews. Once all the interviews had been transcribed, the researcher immersed himself in the data, reading and re-reading the transcriptions, thereby obtaining both a broad overview, as well as an in-depth and categorical sense of the data set. Thereafter, each interview was analysed and a number of themes were identified. The researcher then analysed all six interviews and identified the common themes. The diagram that appears on the following page illustrates the overarching thematic map yielded by the analysis of the data.

[5] While these are the 'street names' for these drugs, the formal chemical names are as follows: ecstasy (Methylene-DioxyMethAmphethamine), CAT (Methcathinone), LSD (Lysergic Acid Diethylamide) and marijuana (Cannabis Sativa).

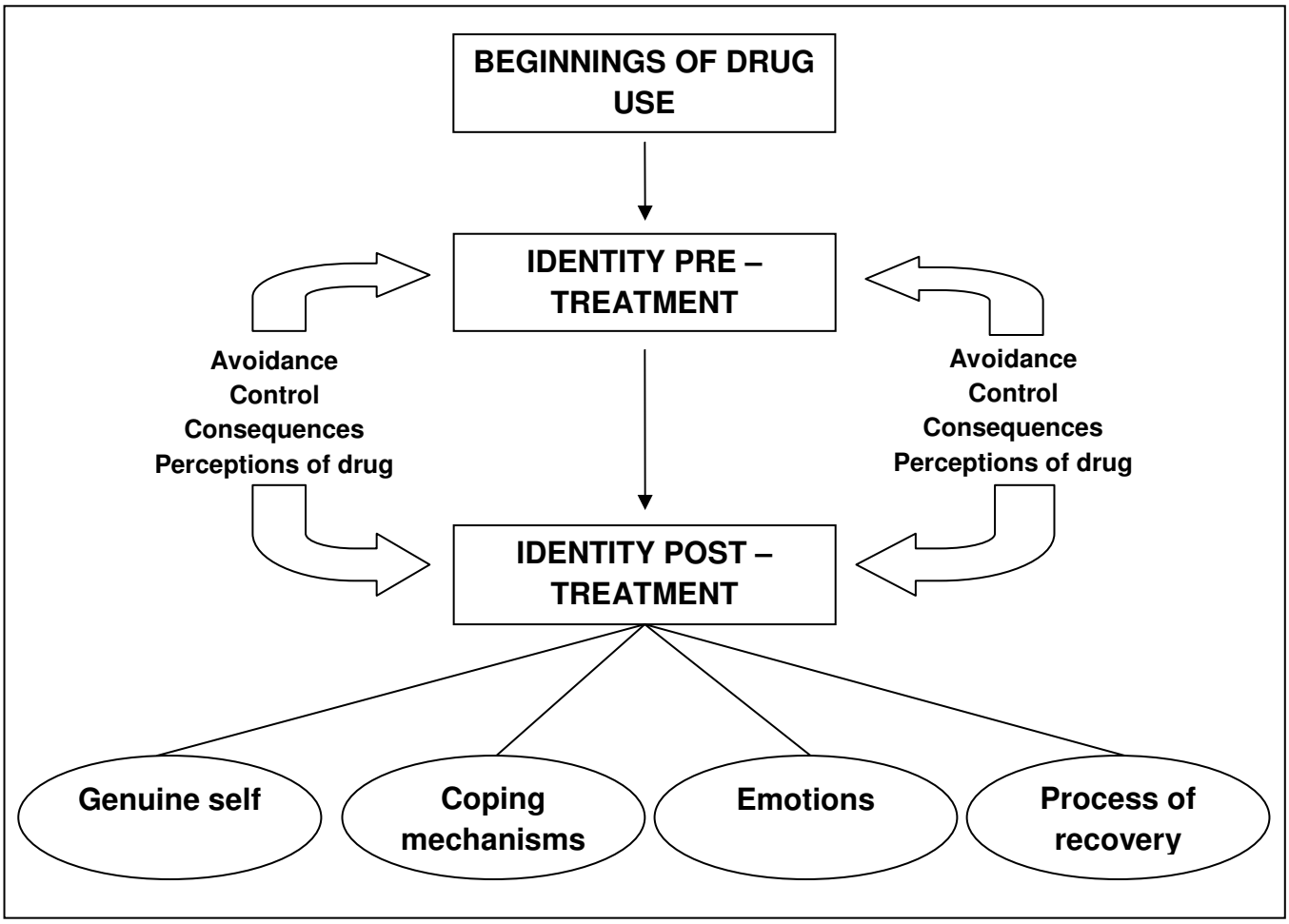


Figure 1: Thematic map of themes identified from the data

A discussion of the 'beginnings of drug use' theme forms the first chronological tier of discussion. Thereafter, the theme of the recovered individuals 'identity pre-treatment' commences, followed by the theme of the recovered individuals 'identity post-treatment'. This theme has been divided into four subthemes, namely the genuine self, coping mechanisms, emotions, and the process of recovery. Finally, the themes of avoidance, control, consequences, and perceptions of drug will be discussed – the researcher has understood these themes as crosscutting between both the 'identity pre-treatment' theme, and the 'identity post-treatment' theme.

The themes have been arranged in a sequential order that closely matches a chronology of addiction and recovery. They have been arranged in this way in order to provide a logical progression, thereby illustrating the process from addiction to recovery and abstinence.

4.4.1. Beginnings of drug use

> "*That's what happens with drugs. You'll start off with the light stuff like "E" or whatever, and oops, you will progress to something else. You start off with a beer or a beer shandy , and the next minute you are wanting to ... to ... taste ... the next best thing*" (Andre).

This was the first theme that the researcher identified from the interviews, and the theme includes six sub-themes, namely, experimentation, early exposure, alcohol abuse, perceptions of the father, trauma, and the idea of an addictive personality.

Experimentation with drugs and alcohol seemed to be an important introduction into the recovered individual's habit. Andre was the first participant who alluded to this idea of experimentation, and describes (with a sense of frustration about himself) his introduction into drugs, "I wanted to try it. Why not?". He compares his initial experimentation with ecstasy to having a glass of wine – when he was offered to try the drug, his initial thought was why not. However, he goes on to say how comfortable he began to feel with ecstasy, and gradually wanted more and more to satisfy his desire. Mark also emphasises this idea of experimentation, when he says that he "started experimenting with some party drugs". A similar introduction was described by Tanya. Although her initial drug use started with Ecstasy, her introduction into her drug of choice, namely cocaine, was experimental in nature: "And they [talking about her friends at the time] said try, and I said no man, and they said how will you know until you try?".

A number of the participants were introduced to either drugs or alcohol at a very early age. Mark noted that the beginnings of his addiction started at the age of 14 when he began drinking. Brendon comments "The first time I got drunk I was eight years old ... no six years old you know ... um ... and I mean like ... fall down drunk, passed out.". He also describes a memory of being five years old and assisting his sister's in making their marijuana joints. Elaine's early exposure into the drug world was at the age of 10 or 11, which was when she had her first Ecstasy tablet. That same night she also smoked marijuana. It seems interesting to note that all three of these participants identified heroin as their primary drug of choice and it can be tentatively proposed that early exposure to the drug world could be a risk factor for later heroin dependence.

This is supported by the hypothesis made by Kandel (1975), the first researcher to allude to the idea that illicit drug use initially begins with legal drugs such as beer/wine and cigarettes, and proceeds in stages. As a result of two longitudinal surveys, she concluded that

> The patterns of all the drugs ever used could be arranged according to a well-defined cumulative and one-dimensional hierarchical order with seven steps: (i) nonuse; (ii) legal drugs only (beer, wine, cigarettes, or hard liquor; (iii) cannabis (marihuana, hashish); (iv) pills (ups, downs, tranquilizers); (v) psychedelics (LSD, other psychedelics); (vi) cocaine; and (vii) heroin (Kandel, 1975, p. 912).

Her original research has become known as the Gateway Hypothesis, although it's more recent appeal has been to the link between the use of marijuana and subsequent use of other illicit drugs (Kandel, Yamaguchi, & Klein, 2006). As has been noted in the previous paragraphs, a number of the research participants mentioned early exposure to both alcohol as well as marijuana and this early exposure may have had a significant impact on their addiction.

A contradiction needs to be noted here. Scott et al. (2005) found (amongst other factors) that those individuals who made the transition to abstinence were older when they first used drugs or alcohol (mean age of first use was 16.8 years). The participants in the current study, however, were initiated into the world of substance abuse much earlier (Brendon was eight years old, Elaine was approximately 10 years old, and Mark was 14). While the current sample size is relatively small, it does suggest the need for more research to be conducted in order to assess the validity of the finding by Scott et al. (2005).

Alcohol abuse and dependence was an especially common sub-theme across all of the interviews. Often alcohol was used together with the drug of choice, hence most of the participants acknowledged that they were in some way or other dependent on alcohol as well. Lee acknowledges this when she says that "So in my head, I don't separate the two. It's kind of like my drug of choice was alcohol and cocaine". Tanya also discloses that "I must say with alcohol, while I was married to this husband, if I think back now unbeknown to me then, I do believe I had a drinking problem then too. Once I started with wine I couldn't stop". Perhaps the alcohol abuse was in fact a learned behaviour, as will be discussed in the following paragraph.

The early exposure to drugs and alcohol dependence is in some way related to the following sub-theme, namely the participant's perceptions of their fathers. While Tanya speaks with much affection about her father, she does state that during her teenage years, she "butted heads" with him a lot. Elaine and Mark currently experience a strained relationship with their fathers, as both of them stress how their fathers were alcoholics. It was clear that Elaine has a particularly troubled relationship with her father: "I was sexually molested from a very young age by my father for as far back as I can remember, from about four years old". Brendon also claims that his father had been an abusive alcoholic. Hence, this sub-theme of alcoholic fathers is related to the sub-theme of early exposure to drugs and dependence on alcohol.

A certain amount of trauma was also quite evident in the analysis, particularly in the lives of Elaine and Lee. As has already been mentioned, Elaine was sexually abused by her father, and she reports a number of sexual violations throughout her history. Lee describes a sense of emotional abuse from a previous boyfriend, whom she dated while using drugs.

While this idea of trauma was not the most dominant theme that arose from the analysis, it is consistent with research conducted by Brown, Recupero, & Stout (1995). These researchers conducted an investigation into the prevalence of posttraumatic stress disorder (PTSD) among a sample of treatment seeking substance abusers. They conclude that "an appreciable proportion of treatment-seeking substance abusers have trauma histories and present with significant PTSD symptomatology" (Brown et al., 1995, p. 253). None of the research subjects had received treatment exclusively for their trauma-related problems. The researchers therefore recommend that substance abuse treatment providers need to consider the possibility of a trauma history for any of their 'revolving door' patients. The inference made here seems to be that if the trauma is treated, it may resolve the continual cycle of dependence on drugs.

As has been discussed in Chapter Two, Hoffman & Kooyman (1996) argue that the family life of substance abusers is often characterised by relative dysfunction (for example verbal, physical, or sexual abuse, and alcoholic parents). They draw on

attachment theory to conclude that the drug dependent person may not have formed close attachments to their primary caregivers, resulting in an attachment to a neutral object (their drug of choice) as a 'secure base' from which to explore the world. This somewhat dysfunctional family background was seen in some of the participants, and can be assumed to have had an influential role in their addiction. That being said, family relationships also served as a support system by encouraging the participant to remain drug free (which will further be elaborated on later in this discussion chapter). This is consistent with systemic theory arguments which state that no behaviour can be understood without considering the particular context of that behaviour. Thus, the conclusion reached here is that while individual choice plays a crucial role in both beginning and ending drug dependence, it interacts and is influenced by the other systems that the individual is a part of, which in this instance, is the family system.

While some of these sub-themes do seem to provide various understandings into the beginnings of the participants drug use, an interesting sub-theme that is related to this genesis was that of the addictive personality. Two of the participants (Brendon and Tanya) mentioned having an addictive nature, or an addictive personality. Tanya states quite matter-of-factly that "I have an addictive nature and only looking back in hindsight do I see that yes, I have an addictive nature".

Kerr (1996) points out that research has consistently shown that there is no support for a particular personality type, or specific personality traits, associated with addicted individuals. Since there is no support for this idea of a specific personality type that is addictive in nature, one wonders why the phrase has become so popular in recovering individual's communications. The relapsed participants in Bain's (2004) study regularly spoke about 'the addict within', or 'my addict personality'. Bain (2004) argued that this manner of addressing a part of themselves as being separate was a form of splitting. Sadock & Sadock (2007) state that splitting is a defense mechanism that is used when the individual cannot sustain their ambivalent feelings towards someone or something else and hence divides aspects of their world and the people in it into either good or bad. It is therefore surmised that this term provides the recovering individual with a sense of comfort, as it helps them to understand their addiction in a particular way – by keeping it somewhat separate from their recovering

sense of self. However, most of the participants display a high level of ownership and responsibility for their previous abuse, and do seem able to integrate these 'bad' aspects of themselves into a more cohesive whole; hence it seems plausible to argue that this aspect of themselves may be a residual dynamic that may shift as the length of their abstinence increases. From a systemic perspective, it can further be argued that this splitting could be the systems manner of ensuring the boundaries between subsystems are maintained, therefore avoiding possibly painful feedback loops (Bain, 2004).

4.4.2 Identity Pre-Treatment

The second group of sub-themes has been labelled 'Identity pre-treatment'. Specific sub-themes that are included in this group include the struggle that the recovering individual had with asking for help, the notion that their drug provided a mask for them, the idea that their identity was stagnant when using drugs, a certain degree of rebellion, and a sense of loss.

"It's just a matter of when you feel like you're in trouble, asking for help. I struggle with that still because I was always very independent. So putting yourself out there and asking for help is a risk". This comment, made by Mark, illustrates the sub-theme quite clearly, namely a difficulty asking for help. It seems that part of their identity prior to using drugs was based on a very independent sense of self. However, the foundation for their sense of independence was not based on the idea of self-worth, but on the idea that "asking for help is a risk" which would make the drug dependent person feel vulnerable. Elaine relates how her therapist in a sense forced her to phone her and talk to her, "because I just don't ask for help, I can do it myself. Self sufficient". It is possible that the drug dependent individual had learnt that there is really only one person that they could rely on, and that was themselves. Yet, as will be discussed later, their sense of 'who they were' was so distorted, that they could really only rely on their drug of choice to help them. However, even their drug of choice started to fail them towards the end, as their tolerance levels increased. Elaine notes how "it stopped working for me in the end. In the sense that I would use and use and use and then I would want to die because with the amount

that I was using, I was expecting to O.D. [over dose]. And I just never did and I got pissed off when I woke up".

Another frequent sub-theme that was identified in the interviews was the sense that their drug of choice provided a mask or a façade for the drug dependent person. Tanya poignantly states that "because in myself I was so desperate and the more desperation I felt, the more grams I'd buy, the more red wine I'd drink – only for the emptiness and despair and desolation to still be there in the morning". The statement by Mark also insinuated this idea of the drug providing a mask – "When I was using I always felt like I was like I mean the best I could be you know what I mean. It was like um, I didn't have like emotional outbursts, you know, I always was just very calm and collected, I always seemed very in control". Lee describes how she had to keep this façade up, "I can cope with everything, nothing affects me, everything is fine". Elaine also recognises how heroin helped to anaesthetise her completely and provided her with a mask. In a sense she takes the theme to the next systemic level when she stated that "it wasn't the aggression, it was the fact that everybody thought we were normal and we put on this façade that our family was fine and we were normal and we really weren't". Therefore it seems like Elaine felt as though her father's alcohol abuse also provided this façade for their family.

The impression of a stagnant identity while using drugs was an additional sub-theme that was fairly predominant. The theme was first identified in Andre's interview when he claimed that "you do not grow on an emotional and on a mental level... My psychological growth stopped". It was quite interesting that Andre pointed out how one's sense of self stops developing when using drugs. He identified this as one of the reasons why society struggles to relate to the recovering drug dependent person[6]. He used an example of someone who began using drugs at 14, and stopped at 25. Society's expectations of a 25 year old are quite different to a 14 year old, hence when they return to society, they are expected to behave appropriately, but "emotionally they don't think like a 25 they still think like a 14 year old ... they're a teeny bop". Both Mark and Lee contently state that one of their main motivations for

[6] This judgment by society can be seen in the interview with Brendon, as he felt that people judge him unnecessarily.

staying clean is the fact that they are finally growing up and taking on adult responsibilities. This sense of growth is clearly evident in the following statement made by Mark: “And that’s what I started doing at 14 and before I knew it, I was an adult but still a kid and I think that’s what I’ve tried to do in the last year and a half, is really become an adult in an adults body and not just a kid in an adults body”.

Systemically, this could suggest a possible reason why relapse rates are so high. Since the broader societal system struggles to relate and interact with the dependent individual who has just completed a rehabilitation treatment, this could result in a relapse as the system is striving to maintain the homeostatic balance that it is familiar with. It is therefore suggested that individual change is insufficient when treating drug dependence; a much broader systemic transformation is required which should encourage the morphing system to stabilise. This is supported by Marmor (1983), who asserts that “relieving stress in parts of the outer system can sometimes benefit the mental health of an individual more effectively than attempting to modify his or her intrapsychic processes directly” (p. 834).

In addition, this could possibly argue for a stronger emphasis on outpatient treatment since this should ensure that the drug dependent person is able to adjust to their own life system, instead of being removed from their natural system, being treated in an unrealistic system, and then being reintroduced into their old system and required to adjust accordingly. This adjustment could possibly be too much for the recovering individual system to cope with, which results in the system relapsing.

In line with their previous identity while using drugs, was the sub-theme of rebellion. Lee recognises that “there’s a big part of me that’s ... like I’ve got a big part of me that’s rebellious ... side to me ... like if you tell me to do something just because you’ve told me I’m not going to do it”. Tanya also acknowledges how she had been somewhat of a rebel in her teenage years, and Mark also confesses how people had told him his whole life that he had so much potential and how he would try to “prove them wrong”. While Elaine does not overtly admit to a rebellious side to herself, it can be inferred from her comments about her school activities: “I wrote poetry and anarchy and fuck the world”.

As noted in Chapter Two, Beavers & Hampson (1993) theorised that individuals with substance abuse problems emerge from mid-range centrifugal families. Children from these types of families do experience some difficulty with authority figures. Thus, there does seem to be some overlap between the rebelliousness that the participants disclosed, and the hypothesis made by Beavers & Hampson (1993). However, as will be discussed later, this sense of rebellion has fallen away to a certain extent, and the recovering individual currently enjoys the sense of responsibility that they experience in their life.

To summarise this grand theme, it seems as if the identity of the drug dependent person was one that was quite fragile. The participants did not feel comfortable engaging with society with a real sense of self, as they may have experienced themselves as not being good enough. Hence, their drug abuse may have provided for them a false sense of security; it afforded them control, confidence, and a way of escaping what they were really feeling. As will be discussed in the following section, it would seem that there has been a shift from a false self to a real, more genuine self through the process of their recovery. In essence, their embryonic real self is in the process of "learning how to assimilate back into a world ... without having to use drugs and alcohol"(Lee).

4.4.3 Identity Post-Treatment

The focus of this chapter now shifts to the theme of the recovering individual's identity post-treatment. This theme will be discussed at length as it is the main focus of the research report. It has been sub-divided into four additional themes (genuine self, coping mechanisms, emotions, and process of recovery) which will each be unpacked and discussed in this section.

4.4.3.1 Genuine Self

> *In active addiction I was brash and arrogant. Instead of being brash and arrogant, I am now direct. Um… instead of being a people pleaser, I am now honest. Instead of having an over inflated ego, I have a sense of humility. Instead of pushing my point, I give the facts. Instead of being hard on myself, I give myself a break. Instead of perpetually having the monkey [referring to guilt] on my back, I dissect it and see whether I should own it or let it go. I can look in the mirror and say I love you Tanya and get this warm feeling inside that's says OK, you're getting there girl. Instead of being intolerant; I have a*

> *lot more tolerance. Instead of throwing in the towel, like I have for 37 years, I'm saying I hate throwing in the towel; I ain't throwing in the towel. I voice my opinion and I'm able to agree to disagree* (Tanya).

The extract above seems to provide evidence for a marked change in Tanya's sense of self. Mark spoke about the entire experience of recovery as a 'rebirth', as though he had been given a second chance to live life again. The process does seem to be reminiscent of a religious experience in a way, and will be further discussed under the sub-theme of spirituality.

Perhaps one of the strongest sub-themes in this section was the idea of motivation. Mark proudly states that "Staying clean is not just about staying clean now, it's about bettering myself". In addition, Tanya asserts that "I made the decision that if anything, this is what I was going to do right". What seems to have taken place in the recovering individual is a sense of internal motivation for remaining abstinent. Whereas before their seemed to be an external locus of control, a shift to a more internal locus of control has taken place. Before treatment, the drug dependent individual seems to have experienced their life as being controlled and influenced by outside forces. After treatment, the recovering individual appears to have taken ownership of, and responsibility for, the outcome of his or her life. In addition, their motivations for abstinence also appear to be more internally rewarding – "the stuff that keeps me clean is the fact that every morning I get to wake up with a clear head" (Mark).

This suggestion that the recovered individuals' locus of control has shifted from external to internal does seem to be supported by Luborsky, McKay, Mercer, Johnson, Schmidt, McLellan, & Barber (1995). In a qualitative study with 35 cocaine addicted patients, they found that the conditions for using cocaine tended to be more external, whereas those conditions for not using cocaine tended to be more internal. For example, reasons for refusing cocaine were, amongst others, thoughts of recovery, remembering techniques taught in treatment, understanding the feelings that lead to drug taking, and will-power. They recommend that treatment facilities need to assist patients in taking steps to reduce the stimulating effects of external conditions, and to enhance and strengthen those internal conditions that are likely to help in controlling the urge to use.

A greater level of self-insight was another sub-theme that was identified in the interviews. Sadock & Sadock (2007) note that insight refers to the "conscious recognition of one's own condition. In psychiatry, it refers to the conscious awareness and understanding of one's own psychodynamics and symptoms of maladaptive behaviour; highly important in effecting changes in the personality and behaviour of the person" (p. 279). The participants increased levels of insight can perhaps be accounted for by their strong commitment to service within the drug community. Most participants were involved in facilitating or attending NA meetings, or are in constant contact with their own therapist. These factors could contribute to increased levels of self-reflexivity and self-awareness. An example of this insight can be seen in Lee's acknowledgment that she was adopted – "I've got abandonment issues ... and ... and I think it's definitely tied into my drugging". She also notes how she "needed to be needed by people". Tanya shows a similar degree of insight as she is aware that "there are character defects that I have which on a daily basis I work on". Finally, Brendon shows an increased level of insight by stating "What I became, I created that myself you know".

Rogers (1951) theorised that each individual has a natural tendency towards self-actualisation which is directed towards greater independence and self-responsibility. During infancy, organismic valuing is central and the developing infant attaches certain values to experiences which form part of the self. One of these values is positive regard, and positive self-regard is achieved by the positive regard that is shown to the individual by others. From positive self-regard, the real self develops. However, societal conditions of worth only provide the individual with positive regard when they are worthy. This is called conditional positive regard, and results in conditional positive self-regard and the development of the ideal self.

Rogers (1951) argued that all forms of pathology were a result of the incongruity between the ideal self and the real self, since incongruity between the real and ideal self results in anxiety and to the development of defenses. Thus, according to a Rogerian perspective, drug dependence is an outcome of the 'ideal self'. Conversely, psychological health is promoted when the individual lives according to their real self, and it is this sense of a real self that seems to be present in the participants of this study.

It seems that there has been a development of a genuine self concept, with a strong sense that the recovering individual has accepted their drug using past, learnt from their mistakes, and has been able to integrate their past into their present day life. Elaine claims that “It takes strength to look at yourself as well and actually be honest about who you are and your dark side too, and accepting that side of yourself as well”. Lee happily states that “I can’t believe my life today, like I’m happy”. This sense of greater self-love and acceptance is also seen in Tanya’s statement: “I am at peace, I know who I am”. Mark also notes the change: “It’s like a true confidence in myself and in my abilities”. The recovering individual seems to have a strong self-awareness and has learnt through experience where his or her weaknesses lie. For example, Lee humorously acknowledges her weakness with alcohol: “I don’t want a glass... I don’t even want a case of wine ... I want to go to a wine farm ... and I want to go down to the like cellars and like ... swim ... in the wine”.

Along with this greater awareness of themselves, has come a strong drive for honesty. While Mark acknowledges that honesty is one of the NA spiritual principles, the researcher felt that the sub-theme was strong enough to warrant its own discussion apart from spirituality. The recovering individual seems to have a keen desire to be honest – honest with themselves and honest with other people. This once again refers back to this genuine person that they have become, as they feel that they do not need to please other people anymore, and they feel confident to honestly say how they feel about certain things. Lee illustrates the important role that honesty plays in her life by saying that “I have to be honest. Ok so for me the way I live my programme is not lie about anything because if I lie about the small stuff it becomes easier to lie about the big stuff”. Mark emphasises the vital role that honesty has played in his recovery, as he is aware that with his sales background, it is instinctual for him to be dishonest. His treatment centre felt that he did not have much chance of success unless he based his programme around honesty, and he agreed with them. Finally, Tanya also comments that instead of being a people pleaser, she is now honest.

A sub-theme that is tied in with the previous sub-theme of honesty is that of assertiveness or an enhanced ability to communicate and express themselves. Andre encountered a situation where he ended up being taken to a club by friends,

and a few days later, he experienced cravings. He believed that the craving was a direct result of exposure to the club environment, and felt angry that he had let himself be taken there. As a result, he confronted his friend about the reality of the situation, and requested him to respect his feelings about the matter in order for him not to relapse. In addition, Lee expresses “I’ve learned about how to communicate more effectively. I’ve learned how to express how I feel better and it’s ... like ... bizarre ... but I had to be taught these things”. Elaine states “I’m much more assertive, if I want something, I let people know how I feel on a constant basis”.

Consistent across most of the interviews was a sense of increased spirituality, or connection with a Higher power. This can be seen as a result of the treatment programmes that the recovering individuals were participating in, as the NA programme directly encourages the addict to surrender control or surrender their lives to a Higher power. For some of the participants, this Higher power does not mean God. For example, Elaine believes that “there is a higher version of myself that is guiding me and knows what’s best for me, and that’s my understanding of God or my higher power”. Tanya considers herself as “a spiritual being, I don’t go to church but I believe that the universe, there is a power greater than ourselves”. It is Brendon’s belief that through treatment, he encountered God in Christianity – “...for me the biggest thing ... I think the whole thing for me is that ... that whole spiritual thing. I think if I didn’t have that ... or if that door wasn’t opened for me ... I don’t know where I would be.

Bain (2004) notes that while the principle of surrender to a Higher power is beneficial in that it interrupts the process of denial, she points out that it may in fact encourage a sense of powerlessness and shift the drug dependent persons’ control from internal to external. This reliance on a Higher power has clearly been beneficial for the participants in this research project. There were no indications of ignoring or denying their past; rather, the participants actively reflect on their past and use this as a motivation to remain clean.

It is interesting to note how their sense of agency does shift in this area from internal to external. These subtle shifts were also noted in their perceptions of their therapist as being the help and support necessary to guide them through possible cravings

and challenging experiences, as well as in their perception of themselves as being powerless over their disease (which will be discussed later). The fact that all of the participants had completed rehabilitation programmes that were closely aligned to the Narcotics Anonymous (NA) principles could possibly account for some of these agency shifts. Christo & Franey (1995) note that the NA views on spirituality and the disease nature of addiction could be seen as encouraging an external attributional style. Bradley, Gossop, Brewin, Phillips & Green (1992) evaluated 80 opiate dependent individuals at the time of admission to a treatment facility. When they re-evaluated them six months after treatment, they noted that those who had attributed to themselves greater responsibility for negative outcomes, and who attributed relapse episodes to more personally controllable factors were more likely to have remained abstinent or to have controlled the effects of temporary lapses. Therefore regarding the shifting perceptions of agency, it seems that the recovering participant displays a fair amount of both internal and external agency, with possibly more emphasis on their own internal attributions for their behaviour and recovery.

Another sub-theme that has been included in this section is that of responsibility. In the period before treatment, it seems like the drug dependent person avoided any kind of responsibility, and was in fact irresponsible – “I just wanted to have fun and not take responsibility but now there’s been a big change in that” (Mark). Their current life is characterised by responsibility, or trying to take back their responsibility. Lee notes that this is what she loves most about her life now, “is that I am accountable and I am responsible”. Mark also acknowledged to a friend of his whom he no longer sees that “he’s got to accept responsibility for his life and I have to accept responsibility for mine”.

As has already been briefly mentioned, there was a consistent sub-theme of service. Mark states excitedly that “I get to do great stuff like the meeting facilitation for the adolescent programme, and I get to give back and I get to go to NA meetings and share on my recovery”. Brendon was also involved in serving after he finished his treatment programme, as the treatment facility asked him to stay on for a few months and ‘give back’. Lee is currently in the process of completing her third year of social work and will be involved in an occupation where service is a requirement. Additionally, Elaine is an addictions counsellor and feels that “the amazing thing

about my job is that I'm faced with people in the throws of their addiction every day". To conclude this section, Tanya says that "for me I can only keep what I have if I give it away, so I throw myself into service; lock, stock and barrel. Most of my free time is spent working with other recovering addicts".

Drawing once again on systemic notions, the participants' service involvement could be perceived to be a form of negative feedback. Negative feedback results in no change taking place within the system, and could thus preserve the homeostasis that the recovering system has achieved. By being involved in service, the participants are confronted and reminded about consequences and motivations for their abstinence, which results in a determined attitude to maintain their recovery.

All of the participants are actively involved in aftercare programmes, whether attending or leading these groups. This can be seen to be one of the protective factors that assisted them in maintaining their abstinence for so long. McKay et al. (1995) assessed the relapse process, and found that one of the experiences that was most likely to precede a cocaine relapse was not participating in self-help programmes. The importance of these groups for the recovering individuals can therefore not be overemphasised. In addition, Bain (2004) identified the theme of loneliness as being one of the feelings that her participants experienced with regards to the relapse process. It can be suggested that those individuals who are able to remain abstinent have found a useful way to channel these feelings of loneliness into more healthy alternatives (such as participating in aftercare groups or getting involved in other service related activities), thus avoiding the lonely feelings that may have motivated their drug dependence.

The final sub-theme that falls under the broader theme of genuine self is that of self-care. The recovering individual seems to have gained a sense of worth through the process, and is happy and at peace with who they are as individuals. As a result, they realise the importance of looking after their own needs. Elaine proudly says that "I respect myself and I deserve respect which is something that I never thought I deserved". For example, she stated that "this week I have had long baths and looked after myself which I never would have done before". Lee also emphasised that one

of her greatest lessons in treatment was the fact that “you have to learn ... to make time for yourself”.

In this section, the researcher has attempted to show how the theme of a genuine self was extricated from the interviews, and how the sub-themes that have been identified in this section all contribute to this greater sense of a real self. Part of the participant’s identity post-treatment is the use of a number of coping mechanisms. This forms the focus of the next theme.

4.4.3.2 Coping mechanisms

The recovered participant’s describe a number of coping mechanisms that they employ in order to remain abstinent. There is a long list of possible coping mechanisms that treatment programmes suggest, and it seems vital that more research be conducted in this area in order to identify which mechanisms are the most appropriate and where greater emphasis should be placed. The following coping mechanisms were found to be consistently employed by the recovered participants: thought analysis/dissection and thought control, exercise (such as running and gym), spending time with clean friends, and going to NA meetings. In addition, a number of NA phrases were used frequently in the interviews, and these phrases provide the recovered participant with a cognitive reminder or reinforcement about their decision to abstain. A discussion of these coping mechanisms now ensues.

“I can't allow it [a relapse thought] to go any further than that, in that split second I say ok where are you going with this, I dissect it and find the root of why I am feeling like that” (Tanya). This sub-theme of thought analysis/dissection is one of the useful coping mechanisms that some of the participants used. Tanya goes on to say that she controls her thoughts, and that “the craving or the desire to use doesn’t come from nowhere, there’s always a root; a feeling of worthlessness, a feeling of low self esteem, a feeling of not being good enough”. The recovering participants note that when they have a using thought, or a desire to return to drug use, they stop the thought, analyse where it came from, and learn from this process. Andre notes that “If I think of drugs, I’ve got to get it out of my mind as quick as possible” and he recounts what his treatment centre taught him to do when those thoughts arise: “Go

sit and think and ask yourself what went wrong". Lee describes how she verbalises her thoughts, and then from there she discusses her motivations with her fiancé, sponsor, and counsellor.

As noted in Chapter Two, Miller (1991) found that those individuals who relapse show a cognitive style that is non-reflective and impulsive, which is related to an inability to use inner speech and other verbal self-regulatory mechanisms to evaluate, plan, and guide their behaviour. From the preceding paragraph, one can see quite clearly the converse of what Miller (1991) identified. The participants in this research showed a very different cognitive style, one characterised by self-reflexivity and verbal self-regulation. While this is a coping mechanism, it also appears to be a cognitive style that is different from those individuals who relapse.

An additional coping mechanism that the recovered participants apply in their everyday lives is that of exercise. "I'll do the next positive thing, whether it's get to the gym or like I train at the gym but I also box so just putting the bag up and you know venting all your frustrations on a heavy bag is the best outlet. Or I just go for a run...". Lee also acknowledges that gym and exercise are important in her life, and Elaine says "I run, so that vents a lot of my stuff as well, as I said before I have a lot of energy so I have to run otherwise I go a little bit insane". It would seem that the exercise provides a healthy emotional outlet for the recovered individual to use, as both Elaine and Mark describe themselves as 'venting' in the process.

Spending time with clean friends is another coping mechanism employed, and it also seems like somewhat of a strategic decision. Lee notes "I had broken away from ... like my immediate circle to find people who were doing what I was doing". She goes on to say how she has got a very small group of recovering friends, and this is who she chooses to associate with. When Mark is facing a stressful situation and thoughts of using enter his head, he also gets around some of his friends from the program who are clean. While the recovering individual spends time with their clean friends, they are reminded about the reasons for maintaining abstinence. In addition, there seems to be a strong element of support experienced in these friends company (which will be discussed later), and a sense that amongst these friends, "the relationships come from such a loving place, because everybody can relate to

everybody else, purely because of where you've been" (Tanya). As Tanya notes, they are always encouraged to "stick with the winners".

Finally, going to an NA meeting was also seen as being a useful coping mechanism for the recovering participant. This was stated by Mark, as well as Tanya, and it can be understood because at these meetings they openly share with their fellow recovering friends about their struggles, and so it can be closely associated with the previous sub-theme of spending time with clean friends.

There were a number of NA phrases that were regularly used in the interviews. For example, both Mark and Tanya describe '*doing the next positive/right thing'*. This reminds them to keep doing positive things and in that way, this should lead them to living a better life (although Tanya does acknowledge that for a while she has been trying to do the next right thing but has ignored some other issues in her life which are beginning to surface with her daughter). Another NA phrase that arose was that of '*just for today*'. Mark describes what he understands by the phrase: "Basically, you know, don't live in the past, don't live in the future, live just for today and if you can stay clean just for today then tomorrow is another day". Tanya also finds this phrase to be a useful coping mechanism. She says "I wake up in the morning and I say it doesn't matter what happens today, I will not pick up today. Yesterday is gone, I can do nothing about it and tomorrow is still coming but just for today I can make that decision". The third common NA phrase that was identified in the interviews was '*Don't pick up no matter what'*. This encourages the recovering individual to remember that "no matter how bad my day to day life could ever get the worst day I have now is still 1000 times better than the best day I had using and that's never been more true" (Mark). Lee also mentioned this phrase. A quote by Tanya summarises this paragraph especially well: "So for me, it's about doing the next right thing, just for today, the next right thing is not picking up, just for today. Because if I'm able to do that, everything else works in my life".

The coping mechanisms identified here are consistent with those classified by Gossop et al. (2002), and offer support to their conclusion that the clients in the abstinent group make greater use of avoidance and distraction coping responses. Specific to this study, the participants cut off ties with their old friends and remained

with people who supported their sobriety (avoidance). They engaged in physical activity and thought changes (distraction). Moreover, the NA phrases can be seen as a cognitive coping mechanism as it positively affirms their decisions not to use.

The final sub-theme that has been labelled as a coping mechanism for the recovering individual is the NA metaphor called '*playing the movie through*'. Lee explains what the metaphor means for her: "so when a craving comes, or if you think of using, you ... you ... it's like putting in a DVD and pushing pause ... at like the best part... and I was taught that you've got to play it through until you want to vomit. What is the feeling where you actually think like I'm going to throw up because I feel so sick?" The phrase was used by Brendon, Lee, and Elaine. *Playing the movie through* until the end promotes long-term thinking. Brendon states that "addicts don't do that because they just think about now ... you know, when you use now. But they don't think like, shit, when I wake up tomorrow morning I'm going to have a hangover, or I'm going to crave".

Bain (2004) notes how short term relief is the aim for those individuals who relapse. It does seem logical therefore that those persons who are able to maintain their abstinence are able to delay gratification of instant desires, and think about what the long term consequences are if they were to act on their impulse to use. This is also supported by Miller's (1991) description of some of the predictors of relapse, namely an impulsive personality profile. As noted, *playing the movie through* can be seen as a way of promoting long term thinking, and encouraging the participant not to be impulsive and to delay gratification.

4.4.3.3 Emotions

The theme of emotions was prevalent in all of the interviews. It seems like engaging with their emotions was quite a natural task for most of the recovered participants, and they spoke freely about them. What was especially clear was that their drug habit was a method used to avoid dealing with emotions, and that "one of the hardest things was learning to deal with my emotions" (Brendon). This will be discussed later under the theme of avoidance. While there were some mixed emotions described in the interviews (such as anger and depression), the most consistent emotions were gratitude and pride. For this section of the research report,

the theme of emotion will be divided into these two sub-themes and they will be discussed individually.

Although not every participant discussed the sense of gratitude, there were a number of statements which clearly implied this feeling. For example, Tanya states that “I am actually blessed to know this programme”. For her, the NA programme has become a life programme, and there is the sense that she is grateful for that. She states this explicitly later in the interview: “I am filled with gratitude. My gratitude knows no bounds as to where I am in my life right now”. Lee comments “I am so grateful for, for how people have responded to me getting, how they have responded to me getting help, and in the decisions that I make on how to live”. Andre contently expresses that “It’s, it’s so awesome. What I used to take for granted before I was an addict is now the reasons for me to be sober”. He then goes on to list a number of experiences which he appreciates and is thankful for.

Interestingly, Elaine feels grateful to heroin – “Self mutilation and my eating disorder would have gone on for years and years and years so I’m grateful that I found heroin because it created that rock bottom for me so much sooner”. Elaine also describes how she writes a gratitude list every morning and every night, which is just a simple list of things that she is thankful for. This has been beneficial for her, “because most of the time addicts are not grateful for anything, we focus on the negative” (Elaine). Once again this idea of a different person emerges from this statement – the recovering individual is grateful; whilst in active addiction, they were not grateful for anything.

When the recovering person walks out of their treatment centre, Andre states that they are in a very fragile state. Tanya notes that that is the time when reality sets in, where they are not protected by four walls. Subsequent to this difficult process of reintegrating into society without using drugs, the recovering person experiences a deep sense of pride in their achievement of remaining abstinent. This feeling of pride can be linked to the point made earlier regarding the difficulties that the recovering person experiences when trying to reintegrate into society. Thus one of the reasons for this deep sense of pride could be the fact that they have managed to reintegrate

back into society. This is the second sub-theme that the researcher identified from the interviews – a coalesced feeling of pride.

Elaine describes how she feels like she has had to claw her way back from a really terrible place, and then says “I’m proud of myself, its testament to my strength as well”. Brendon also experiences a great deal of pride for what he has achieved during his recovery. Mark points out how he feels that “There’s a sense of pride as well about the personal growth” that he has achieved, and Lee also states “I’m proud, I’m very proud of myself”. It would seem that this feeling of pride also links back into this new identity that they now embrace. Mark regretfully says “I did some nasty things in my day and I’m not too proud of it”. Based on this comment the researcher suggests that the identity pre-treatment was one where pride was a foreign emotion, and where shame and guilt were common-place. The identity post-treatment is characterised by a deeply satisfying sense of pride. While there is a sentiment of regret for the many losses they encountered, they are able to counter this regret with a sense of pride and accomplishment for where they now stand. This feeling of pride boosts their self-esteem levels and assists them in feeling at peace with their current, more genuine self.

4.4.3.4 Process of recovery

As has been discussed already, the recovering individual is aware of where his or her weaknesses lie. As a result, there is a sense that “I have to be vigilant all the time. I cannot let my guard down” (Carmen). This vigilance is important for them as “the possibility for a relapse will always be there” (Andre). In a later theme the researcher will discuss how the recovering individual’s perception of their drug has changed. However, as a result of the perception that “this disease is cunning, baffling and powerful”, Tanya feels that if she’s “not ten steps ahead and vigilant all the time, it’s gonna bite you in the ass every single time”. Andre concludes that “If you are vigilant, and practice everything you are taught, you will succeed”.

The importance of structure was emphasised by some of the recovering participants. The idea that the recovering individual needs to ‘stick to a programme’ is encouraged by treatment facilities. Andre explains that sticking to a programme means that if you know that a Friday night was normally the night that you would use

drugs, you need to make a programme for yourself that will keep you busy on a Friday night. Lee adds “On the weekend, Saturdays are hard for you, the weekends are like the worst for people in the beginning of recovery, so here is a little piece of paper, we are going to write down, what are you going to do every step of the way”. The importance of this concept of ‘sticking to a programme’ seems to provide the recovering individual with a sense of control. It could also be an attempt to ensure that free time and periods of boredom are not utilised for activities that may encourage a relapse.

Miller (1991) notes that individuals who relapse show poor outcomes on measures for planning, and Fisher et al. (1998) found that those individuals who relapse showed lower levels of conscientiousness on the NEO Personality Inventory. These researchers’ findings are consistent with the current research as it can be seen how the recovered individual displays a good ability to plan ahead, so as not to encounter situations where thoughts to use drugs again arise; thus one can assume that their levels of conscientiousness appear to be high.

When enquiring about possible situations where the participants have considered using drugs again, Mark identified that “Stress is probably the number one factor”. Stressful situations seemed to be a common factor that had resulted in the participants feeling like they wanted to use drugs again. Tanya and Mark described some stressful work situations that they have encountered where the thought to begin again has emerged. Lee illustrates her stressful situation by saying “I’m getting married at the end of the year, there’s like a whole lot of stuff around that that was stressing me out. Then I had this thing going on with my religion, I was under pressure from varsity, there was like, there was so many things going on. Like I felt like a pressure cooker, like if one more thing happens, I’m going to, I’m just going to explode”. It is in these stressful situations where the recovering person employs their now familiar coping mechanisms of thought analysis and control, communicating their desires to their support structures (family members, sponsors, and counsellors) and exercise.

This idea of stressful situations leading to thoughts of using again by the recovering individual is consistent with the literature. As has been noted in Chapter Two,

Stewart (2000) pointed out that when rats were exposed to a brief period of stress, they were more likely to reinstate their drug use behaviour. Moreover, it was shown by Sinha (2001) that internal cues such as stress responses can function as conditioned stimuli which are capable of eliciting craving. Marlatt & George (1984) found that in approximately 34 percent of relapsed individuals, emotional stress was offered as the motivation for their relapse. Based on these results, one can see just how critical it is that drug dependent persons are provided with coping mechanisms to deal with these stressful encounters.

Regarding the most beneficial aspects of their treatment programmes, Mark, Lee and Elaine all agreed that they found the cognitive didactic groups tremendously important. It needs to be mentioned that the three participants who stated that this was the most beneficial for them all attended the same treatment programme and all three have some background in the study of psychology. This could possibly suggest that their exposure to these ideas before treatment may have provided them with a platform to build and expand upon. This proposition is supported by Mark's statement that "It was like going back to varsity and redoing the work but this time with a better understanding of it". Hence a possible recommendation for treatment programmes that emerges from this is that greater emphasis needs to be placed on educating the drug dependent person about the cognitive aspects of their disease.

A dominant sub-theme that has been identified across all the interviews was that of support. The recovering participants experience a tremendous amount of support from family, friends, counsellors, and sponsors. Whilst it needs to be acknowledged that this was one of the questions asked of the participants, the concept of support emerged in the interviews prior to the question being asked by the researcher. Andre felt that without aftercare (which is a support provider) he would not have made it as far as he has. Mark also describes his support as coming from his mother, sisters, friends from treatment and NA, and his counsellor. For Lee and Tanya, they noted especially how supportive their families have been during their recovery. Tanya notes that "My family have been, well… if I have to put it on a scale of 1 to 10, they have been a 1000 times supportive". Lee recognizes how devastated her family was when they first found out about her addiction, but notes that since then, "My family have been amazing. Absolutely amazing".

Thus, the interconnectedness and importance of the various sub-systems in the broader recovering system is illustrated here. While the individual sub-system has changed, this change can only be maintained if the other sub-systems which interact with this individual change as well. The importance of the family sub-system, friendship sub-system, and treatment sub-systems are therefore critical in maintaining recovery.

In line with these notions, Butler & Bauld (2005) stress how important it is that the family of the drug dependent person are included in the treatment process. While Lee's family was devastated when they first found out about her addiction, the entire family unit entered family therapy. Therefore, by including the family in the treatment process, Lee may have experienced a stronger sense of support.

While Brendon has experienced a strong feeling of support from his family and friends at work, it seems that his strongest sense of support has come from having a relationship with his Higher power. Elaine highlights the important realization that she had: "It was the fact that she [her therapist] was there if I needed her and for me that was the most amazing thing, that people actually gave a shit, they cared". Elaine began to appreciate that there was support for her if she wanted to ask for it. Hence, to conclude this sub-theme of support, Mark recapitulates by saying that "there's a big support network, it's just a matter of when you feel like you're in trouble, asking for help".

The sub-theme identified as 'gifts of recovery' was first encountered in Mark's interview. He spoke about the gifts of recovery not being totally materialistic rewards, but rather, the simpler things in his life such as being able to wake up in the morning with a clear head – that his thought processes and sensibilities are no longer dulled. He feels that his new found confidence is also another gift of recovery. When Andre was asked what keeps him motivated to remain abstinent, he replied "Just to be sober, it is such a wonderful thing. You cannot describe it to somebody. It actually sounds very stupid to say, just to feel, it's just the rewards you get on a daily basis". The reward that Lee experiences on a daily basis is the knowledge that she does not have to lie about anything. In the past, she felt quite paranoid that someone would catch her for doing something wrong. Her feeling of knowing she has been honest,

“that’s what I love most about my life now”. This idea of gifts of recovery is in part linked to the deep emotion of gratitude that the recovering individual experiences.

What was quite consistent across most of the interviews was the sense that the recovering participant experiences a great deal of admiration and respect for their therapist and their treatment programme. There was most definitely a positive experience between the participant and their therapist, and it can be inferred that this is one of the crucial aspects of an individual’s recovery. Andre experienced his treatment as being “fantastic”. Mark felt as though his counsellor was “brilliant at establishing rapport and trust early on”, and he felt confident that if he phoned her at three in the morning that she would be available for him. Lee has a similar feeling of knowing that she can contact her counsellor at any time. In addition, she feels like her treatment centre is one of the best and that the way they structure their programme is the correct way. Tanya speaks about feeling privileged that she had the therapist that she had, and Elaine speaks about her therapist as being amazing.

This idea of the power of the therapist as ushering the drug dependent person into a healthy and clean new life can be argued to be parallel to a religious experience of salvation and therefore is linked back to the notion of spirituality. In many religions, the priest is seen as the divine mediator between man and their God, and this results in much admiration and respect for that office. Additionally, the priest adopts a shepherding role by guiding the worshipper along their spiritual journey. In a similar way the recovering individual holds much respect for their therapist since they have, in many respects, given them a new life. Furthermore, it is the therapist who continues to guide the recovering individual as they negotiate the ups and downs of their new life. Once again, disparities in internal and external locus of control can be identified here, as was discussed earlier.

The idea of ‘choice in relapse’ was a steady sub-theme that the researcher encountered in his analysis of the data. The issue has already been debated in the literature review, and it would seem that the participants firmly believe that drug use is a choice. From the first interview already this idea about choice emerged, and it was in this interview where Andre used the metaphor of a magnet to describe the process. He compared the drug to a magnet, and himself to a metal pin, and

described how treatment moves the magnet away from the pin. However, “it’s up to you to ensure that you don’t get close to that magnet again” (Andre). Tanya adds that for her, “it was about choice, I made up my mind that today I choose not to use”. This choice not to use is actually a decision that the recovering person makes every day. Lee says “I believe that relapse is an option for me every day, every day I have the choice to use, every day I wake up and I choose not to use”. This sub-theme emerged right until the final interview with Elaine who said that “It’s a choice, it comes from the person, and it’s a choice”.

West (2001) argued that addiction violates the individuals’ freedom of choice in that it results in the dependent person compulsively seeking their drug of choice. This perception seems to contradict what most of the participants experienced. Choice was crucial to their recovery, and thus their views around this perception are more consistent with Kerr’s (1996) conclusion that substance dependence involves a free choice.

Brendon points out that “as time has gone by, those sort of thoughts have become less”. He was referring to his thoughts to pick up drugs again. Tanya also notes that “the time span between the cravings has got longer and longer”. In addition, Lee acknowledged how her thoughts to use drugs again have diminished. Most of the recovering participants emphasise how difficult the process of recovery has been, for example Brendon states that “It’s been hard, it hasn’t been that easy”. Elaine confirms the difficulty of the process. The message identified by the researcher was that recovery is not an easy task and it is going to require hard work and dedication. However, it is possible.

Finally, most of the recovering participants describe a sense of uniqueness to the process of recovery. Andre pointed out that there are different scenarios and situations for different patients, and Brendon stressed that “everybody has got a different process to go through”. Elaine also pointed out how everyone is unique and that we cannot treat everybody in the same manner. This has some important implications for treatment programmes. While emphasis has to be placed on providing the drug dependent person with structure, a balance needs to be found in order to let the addict have his or her own process of recovery. For the researcher,

this was an important learning experience – it made him realise that there is no one correct way to treat addiction, and that the issue of treatment is much more complex than imagined.

To conclude this section concerning the identity of the recovering individual post-treatment, the researcher has argued for the predominance of this theme in the research interviews. It was suggested that there has been a shift in the recovering individual's sense of identity to a more genuine sense of self; one where more effective coping mechanisms are utilised, and where emotions of gratitude and pride seem to dominate. The interesting vacillations between internal and external locus of control were also discussed. Finally, it was stressed how the process of recovery had been an important learning experience for the recovering participant, and while it had been hard work, most of the participant's experience satisfaction with the person that they have become (echoed by Tanya's words, "I'm at peace with who I am").

The following four themes that will be discussed share a significant overlap between both the identity pre-treatment and identity post-treatment themes.

4.4.4 Avoidance

The theme of avoidance seemed to be constructed in the interviews as a two-sided coin. On the one side, the drug dependent person pre-treatment used drugs to avoid emotions and reality. On the other side, the recovering individual now seems to avoid dangerous people, places and things. A discussion of this theme now begins.

Using drugs to avoid the emotional experiences of the drug dependent person seemed to be quite a universal experience for the participants. Mark stated that "the minute I started feeling something, like a tightness in my chest which meant I was having an emotional reaction to something, it was like hit the pub, hit the dealer, do whatever, because it made me feel out of sorts, it made me feel like something was missing". The idea of using drugs to avoid emotions was also clear from Tanya's statement "I just wanted to hide away and just blot out all the feelings I had and all the pain and the easiest way to do that was just to use cocaine". Lee notes that she used drugs to make all of her emotional stressors go away, and Elaine felt (at the time) that heroin was a fantastic coping mechanism, "I tried everything else and

heroin was the one that just helped me anesthetize myself completely, blocked me off completely".

These results are consistent with what was delineated in the literature review – that substance use is a self-medicating response to avoid difficult affective states (Baker et al., 2004; Dodes, 1996; Khantzian 1985). The use of drugs to escape emotions was also noted in Bain's (2004) research.

In addition to helping the drug dependent individual avoid emotional experiences, their drug of choice also helped them avoid reality to a certain degree. Brendon asserted "I mean you just avoid, avoid reality hey. And ya, like I said just suppress everything you know. You take drugs and just forget everything". Elaine also points out how she "Didn't like reality so anything that anyone put in front of me, I'd use". Tanya began using drugs at a time in her life when her mother had recently passed away and she had just received divorce papers. She maintains that "I had found something that made me feel as though the world wasn't coming to an end, like everything would be OK".

Following treatment, the recovering individual is encouraged to avoid dangerous people, places and things, and this was also quite a consistent message that the researcher identified from the interviews. Andre noted how he avoids going to clubs because he sees other people using drugs there and he knows from experience that this can trigger a craving to use again. Avoiding dangerous people seems to be the most significant element, and was identified in the interviews with Mark, Tanya, Lee and Elaine. Mark states that he is only in contact with two of his old acquaintances, and Tanya claims that "the friends that I had that are still in active addiction are no longer my friends". This point is also emphasised by Elaine when she states that "All of my friends from back in the day, I'm not friends with any of them, and I've got nothing in common with them".

4.4.5 Control

The theme of control was also dominant in the interviews, and ranged from thoughts that the drug controlled the user and helped them to control their emotions, to

currently experiencing a greater degree of control over their life, as well as surrendering control to a Higher power (therefore overlapping with spirituality).

Regarding control, there were two sub-themes that materialized in terms of the participants identity pre-treatment. Those sub-themes were the emphasis that their drug of choice controlled their everyday lives (this aspect of control was especially prevalent in Bain's (2004) research). The second was the idea of giving up control or surrendering.

There is a sense that the participant's initiation into their drug of choice was initially controlled, but as time progressed, their drug abuse became more and more uncontrolled. Brendon states that "In the beginning, I sort of controlled it ... but towards the end ... I used on a daily basis". Andre used the metaphor of a magnet (which has already been discussed) and comments that "It's [the drug] got this powerful hold on you. It's controlling you completely". Here he illustrates his lack of control of crack usage. The converse argument is that it would seem that their drug of choice helped them feel more in control – this can be seen in the way Mark describes how his drug helped him in that he "didn't have like emotional outbursts, you know, I always was just very calm and collected, I always seemed very in control". As Bain (2004) notes, their drug usage initially promises them the mirage of control but this promised control eventually also becomes out of control, which leaves them feeling more powerless. This is emphasised by Tanya when she says that "Once I started with wine, I couldn't stop", and a very similar statement was made by Lee.

Through the process of their addiction, it would seem that there comes a point when the drug dependent person realises that his or her addiction is in actual fact an addiction which requires some sort of intervention. Hence, the following sub-theme that will be discussed is that of surrendering or giving up control. This point arose in Andre's life when he realised that "I had no choice I've got to seek help, I can't do this on my own, and I was going to ruin everything around me". Similarly, Mark (frustrated with his lack of intelligence for not recognising earlier) realised that "this thing is stronger than me, can you help me out?" This idea of surrendering is linked

to a theme which will be discussed shortly, that of the perception of their drug as being omnipotent.

This theme of control is still a principal theme in their identity post-treatment. In terms of self control, Andre notes how “it is up to you to make sure that you don’t get close to the magnet again”. In addition, Tanya feels happy with her abstinence as she feels that she now has gained control over her life again. It would also seem that control enters the life of the recovering individual predominantly in terms of thought control. Andre states that “if I think of drugs, I’ve got to get it out of my mind as quick as possible”. Similarly, Tanya describes that when the thought to use again enters her mind, she quickly stops the thought, analyses and dissects it, and locates the root of the thought. It can be seen that this strategy of hers is used to control her thoughts.

One can see quite clearly how the theme of control overlaps between both the drug dependent persons’ identity pre-treatment, and the recovering individuals’ identity post treatment.

4.4.6 Consequences

The matter of consequences is another theme which the researcher identified as overlapping between both the identity pre-treatment, and the identity post-treatment of the recovering individual.

In terms of the consequences that the drug dependent person experienced before going into recovery, it seems quite clear that each participant reached a point of ‘rock bottom’, where a deep realisation of the losses that they had encountered arose. This is linked to Finney & Moos’ (1995) *Stress and Coping model* – one of their findings was that people are more likely to enter treatment for their addiction when they are enduring distress or hardship. The first time Andre realised that his problem was indeed a problem was when he over dosed and ended up in a government hospital. He elaborates further by stressing how he had destroyed himself, emotionally, financially, and physically. Mark talks about how he had drained all of his financial resources, had nowhere to go, and had just written off his car. For him, that was his rock bottom – “so I was kind of not even between a rock and a hard place, I was kind of under a rock in a hard place”. Brendon describes how he had

everything in life (including a wife, children, house, and cars) to having nothing now. For Tanya, her point of rock bottom was physical, spiritual and mental, “it was a feeling of hopelessness that I was in a dark pit of despair that there was nowhere else that I can go other than up”. Elaine’s rock bottom was an emotional one, and Lee admits that “sometimes I felt like killing myself because like, I couldn’t stop. I hated it”.

Mark asserts that unless you have lost significant things, and until you feel the full brunt of the consequences (as opposed to your parent’s bailing you out), “you don’t make that solid commitment to recovery”. All of the participants reached their rock bottom prior to treatment. When the recovering participant thinks back retrospectively, it seems that they are reminded of those consequences that they brought upon themselves. Hence, thinking about those consequences is one of their motivating factors for remaining clean. Brendon determinedly says that “I’ve got to keep reminding myself what the consequences are”. He then goes on to describe how ‘playing the movie through’ (a sub-theme already discussed) helps him to think of the possible consequences. In addition, Lee stresses how thinking about her upcoming wedding and marriage, as well as her desire to be a responsible mother motivates her to remain clean – “for my future, I keep clean today for the future that I want”. Finally, Elaine notes that working with drug dependent persons as an addiction counsellor helps her remember what the consequences were “and I’m taken back to that time and that’s the thing, you often forget where you come from”. Therefore, it is in looking at the consequences retrospectively, and anticipating the future consequences of a relapse, which helps the recovering individual maintain their abstinence.

This notion of thinking about the possible consequences of a relapse was also displayed in Llorente del Pozo et al.’s (1998) study. As discussed in the literature review, the researchers studied two groups of heroin dependent individuals – those that relapsed and those that were able to maintain abstinence for at least seven months. Approximately 73 percent of the abstinent group considered the positive consequences of abstinence in order to overcome the craving to use. Therefore, the current research results seem to be consistent with Llorente del Pozo et al.’s (1998)

results, and possibly suggests that treatment facilities need to emphasise thinking about the positive consequences of abstinence more strongly.

4.4.7 Perceptions of drug

The final theme that the researcher identified in his analysis of the data concerned the recovering participant's perception of their drug.

Regarding their perceptions of their drug of choice before they entered treatment, it was indicated by both Tanya and Lee that they were initially opposed to drugs. Lee pointed out how she had refused to use drugs because it was the thing that everybody was doing and she wanted to be different. In addition, it was quite clear that in the beginnings of their drug use, the participants viewed their drug as being something that was in actual fact beneficial for them. It provided them with confidence and control over emotional aspects of their lives. Yet, as their usage progressed, the participants began to realise that they had a problem. Both Mark and Elaine stated that towards the end they were simply using heroin in order to avoid the withdrawal effects, as it had stopped working for them.

"I look at my drug differently now" (Lee). There appears to have been a modification in terms of their perception of their drug post-treatment. This matter was grouped by the researcher under the sub-theme of 'the omnipotent drug'. Their perception of their drug as being all-powerful and all-controlling was quite prevalent in the interviews. Mark noted that "I've picked an opponent that's bigger and stronger than me and it kicked my ass". The comment Brendon made illustrates quite well the respect that the recovering participant holds for their drug of choice – "that was how powerful the thing was, the drug is, is that it just like took all of that from me". Within this sub-theme is the idea that the disease and the drug is powerful, and the recovering individual is quite helpless when it comes to this. Tanya emphasises this point when she says that "I've admitted that I'm powerless over this disease, and that when I use, my life is unmanageable". One can see quite clearly here the change that has taken place in her mind – her drug initially helped her make her life manageable, whereas now, she acknowledges that it makes her life more unmanageable. Furthermore, notions of internal and external attributions for her behaviour can be identified within this perception – she has surrendered to the

‘powerful disease’. Elaine concludes that entering treatment ruined her drug addiction completely: “Once I went to rehab, if I had used, I would have had a conscience and then what’s the point? It ruined the using for me, it ruined the high”.

4.5 Conclusion

In this chapter, a comprehensive outline and discussion of the various themes and sub-themes which the researcher identified in his analysis was provided. The specific themes that were discussed included ideas around the beginnings of drug use, the recovering participants identity pre-treatment, their identity post-treatment (which was divided into genuine self, coping mechanisms, emotions, and process of recovery). Finally, four overlapping themes of avoidance, control, consequences and perceptions of their drug were discussed, and it was shown how these four themes overlap between their identity pre-treatment, and their identity post-treatment.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This research aimed to investigate the processes involved in recovery from heroin and cocaine addiction. Six participants were interviewed, with each interview lasting approximately an hour. The drug of choice for three of the participants was heroin, and for the other three participants, cocaine. Based on these interviews, a number of important themes arose and were discussed in chapter four.

5.2 Conclusions drawn from this study

Since systemic theory formed the theoretical basis for this research, a summary of some of the key findings associated with the different sub-systems will be provided.

Most of the research findings emerged from within the intrapsychic sub-system of the recovering individual. Perhaps one of the more notable findings was the shift that seems to have taken place within this intrapsychic sub-system. It was noted that a shift in their sense of self has transpired – from a placatory and avoidant false self, to a real and more genuine self that is characterised by openness, self-reflexivity and honesty. In addition, this sense of self appeared to show strong yearnings for responsibility and was able to tolerate both the negative and positive facets of their lives. There were indications that a shift to a more internal locus of control had been made.

That being said, what was particularly interesting about the research findings was the way in which the recovering participant's sense of agency vacillated throughout the interviews. At times, the focus revolved around how they had made their own commitment to maintaining a drug-free lifestyle. They emphasised how important it was that the motivation for abstinence came from within, and how they chose to follow through with this decision every day. The centrality of individual choice for recovery was stressed.

However, a number of illustrations were highlighted in chapter four which pointed to discrepancies in this conception of internal attribution. For example, increased significance of spirituality in their lives was underscored, which suggested a sense of

external attribution for their recovery. This was also indicated in the value that the participants placed on their therapists as being crucial in the recovery process. Finally, perceiving their drug as all-powerful and themselves as powerless when faced with their drug was an additional contradiction that was noted in the results.

Attention was drawn to research which indicated that drug dependent persons often display strong perceptions of external attributions for their behaviour. Thus, a possible formulation that may explain the inconsistency in attributional style of the recovering participants could suggest that as recovery progresses, so increased levels of internal attribution become more predominant. Accordingly, the indications of external attribution could be some of the residual effects of their previous drug dependent self.

It was shown that the recovering participants utilised a number of coping mechanisms. Most of these were cognitive in nature – thought control and thought analysis, as well as cognitive rehearsal of specific NA phrases which reminded the participant of their commitment. Behavioural coping mechanisms included exercise and avoiding dangerous people, places and things. These also consisted of a dedication to service (possibly resulting in distraction) and attendance of NA meetings.

Concerning the familial and friendship sub-systems, it was shown how the importance of support had been crucial in assisting the recovering participants in maintaining their commitment to abstinence. Socialising with recovering friends and avoiding their previous friendship circles was quite a central point, and the familial support provided them not only with people to talk to about daily challenges, but also with motivation to remain abstinent.

The broader societal sub-system was also included in the discussion about recovery. It was indicated how some of the participants experienced a fair amount of stress when attempting to reintegrate into society without using substances. Society was portrayed as offering little support or understanding of the difficulties that recovering individuals are faced with, and it was suggested that perhaps intervention is excessively focussed on the individual, and not sufficiently aimed at transforming societal perceptions of drug dependent persons.

5.3 Limitations of the study

There are a number of limitations of this study. The sample size is relatively small and so conclusions drawn may be specific to the participants of this study. It would be beneficial to perform the study on a larger number of recovered individuals in order to assess a broader range of experiences. In addition, three of the participants attended the same rehabilitation centre and a number of their comments and experiences were quite similar. It is more than likely that other results may have arisen if participants had come from other rehabilitation centres. Finally, the results obtained are specific to the process of recovery from heroin and cocaine; hence the results may appear very different for other drugs.

5.4 Recommendations

The findings of this study imply a number of recommendations for intervention and further research.

One of the questions asked in the interview concerned recommendations that the recovering participants would make to treatment systems. Their responses to this question in informing recommendations are therefore centrally important. They noted that rehabilitation centres need to ensure that before the patient is discharged they have a support system in place – that they already have a sponsor who they can call when they need to. It was suggested that the family become more involved in the treatment process and that they receive more psychoeducation around substance abuse in order to know the signs which may indicate that their loved one is using drugs again. More individual work with therapists was suggested in order to assist the drug dependent person in identifying the root of their addiction.

Quite a consistent recommendation was that the importance of aftercare needs to be stressed. In these aftercare groups, or NA meetings, the group leaders need to push for emotion. They also need to be quite firm with those individuals who have had a relapse, ‘saying it like it is’. They need to assist the relapsed person to dissect exactly what took place, thereby encouraging him or her to learn from the relapse. The power of the group was stressed, and knowing that they had support from their

fellow group members was beneficial. Some of them found the cognitive elements of the group work especially important.

In addition, they were asked what they would tell someone who constantly relapses. Some of their responses included the idea that the recovering person needs to make time for themselves. The importance of planning their day to day activities was highlighted. These individuals needed to be challenged to think about the relapse and to see how their constant relapsing is serving them, in other words, what are they getting out of it? They needed to know that recovery is not easy, and that it is going to take work, but it is possible. Strongly encouraging these individuals to talk about themselves and to ask for help when they need it was also recommended. Based on this research, a number of other recommendations have arisen.

Perhaps the strongest recommendation is that the drug dependent person needs to engage with their real reasons for using drugs. A deeper level of insight needs to be fostered through much more self-reflective work (be it through aftercare programmes or personal psychotherapy). This should allow the individual to take ownership of his or her problem. Their own internal resources should be enhanced and strengthened in order to control the urge to use. In addition, this work should encourage them to integrate both the good and the less good parts of themselves, and to realise that both these parts can co-exist within the same person. Honesty and self-confident assertiveness should be promoted, thereby reducing the strong desire within the drug dependent person to please other people.

Furthermore, treatment providers need to assess for indications of post-traumatic stress disorder and if there are any indications of residual trauma, this should be the focus of treatment and should be addressed before the substance abuse issues.

Endorsing a philosophy of service to others was especially beneficial for most of the research participants; hence an additional recommendation is that recovering individuals should be urged to get involved in service programmes as much as possible. This should not only assist them in planning and structuring their time, but should also counter feelings of loneliness.

A number of the participants emphasised just how different each individual's recovery is, and that nobody's process is the same. It can therefore be suggested that treatment programmes adopt more of a flexible and individualistic focus, tailoring specific treatment to each individual.

5.5 Conclusion

Since relapse is such a common occurrence in the substance abuse field, it is crucial that more research be undertaken within South Africa concerning the process of relapse and recovery. In so doing, more comprehensive studies in this field could contribute to further recommendations and refinement being made to treatment programmes throughout the country. Importantly, such interventions should always consider a systemic frame of reference, thereby ensuring that no sub-system be isolated when both theorising and intervening to ensure that people in recovery remain sustainably drug-free.

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