A Phenomenological Study of How People with Co-occurring Disorders Have Managed to Achieve a State of Full Recovery.

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A Thesis Proposal Submitted to the Psychology Department School of Human and Community Development University of Witwatersrand in Partial Fulfilment of the Degree of Master of Arts Degree in Psychology by Dissertation.

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February 2016

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Declaration

This report is submitted in partial fulfilment of the requirement for the degree of MA by Dissertation in Psychology in the faculty of humanities,

University of the Witswatersrand

Johannesburg

2016

I declare that this project is my own, unaided work. It has not been submitted before for any degree or examination at this or any other university. All sources have been correctly referenced using the APA format of referencing.

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Alistair Geoffrey Heald
A Phenomenological Study of How People ...

Alistair Heald

Masters in psychology Date 03/02/2016

Acknowledgements

This has been a difficult research project. The hours I have spent reading, typing and listening did not come easily. However there were several people who performed an integral role in helping me through the many hours that it took to complete the project. I would like to thank these people individually.

Firstly I would like to thank my father who showed a consistent interest in this project even when I struggled to come to terms with the work that needed to be done. Being young, inexperienced and adamant about exploring a new research area led me to feel overwhelmed once I had realised the gravity and complexity of addiction and co-occurring disorders. By taking my interests seriously you gave me the fuel I needed to reach ever deeper into myself to complete this project in an authentic manner. Thank you dad.

I would also like to thank my supervisor Dr Malose Langa. Thank you for helping me with this project. Together your attention to details that I may have otherwise overlooked and your unbelievable knowledge of addiction gave me the tools I needed to forge a relevant and meaningful thesis on co-occurring disorders. I also want to thank you for trusting me with this topic. By this I mean you have allowed me to explore this research area on my own and given me the space I need to express myself. You have supplied me with essential guidance when I have needed it but also assumed a level of responsibility in me that pushed me closer to reaching my potential. Thank you.

Lastly I want to thank my friends Etienne and Luke. Thanks to you Etienne my teeth will be yellow before I am thirty because of all the coffee we have drank together while discussing fresh new ideas. Thank for continually providing me with a knowledgeable sounding board and great new ideas. You have been a source of ongoing strength and support for me and I am proud and privileged to have you as my friend.

Finally I would like to extend a special thanks to my friend Luke. It goes without saying that you have made this journey a lot easier and much more enjoyable for me. Thank you for always being supportive and for helping me to stay on the right path when I have felt doubt. Thanks pal

Abstract

This study was aimed at an in-depth exploration of the recovery experiences of a group of 12 individuals who attended 12 step self-help groups situated in different regions in Johannesburg. 12-step self-help groups are presently the largest clinical supplements in the world. Ongoing discussions with the relevant representatives from the fellowships of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were utilised in order to gain access to this population of people. These 12 individuals suffered from substance dependence and one or more co-occurring disorders (CODs) and were interviewed in semi-structured interviews about how their lives had changed since they had achieved a state of recovery and about some of the difficulties they had experienced since the point at which they had achieved remission from their substance-related disorder. The study also focused on the therapeutic aids that the participants had found useful during their time in recovery. In this study, CODs refers to the existence of at least one substance-related disorder and at least one psychiatric disorder in the same individual. The overarching methodological framework that was used in the study was phenomenological. It was evident from the study that the road to recovery is fraught with many challenges that the recovering individual needs to negotiate and that very often there is no information available on what the best course of action to follow is. In conclusion it is evident that recovering addicts, especially those that have been diagnosed with one or more CODs often require ongoing support and care if they are to continue on their journey of recovery.

Keywords: **Addiction, Alcoholics Anonymous, Co-occurring disorders, Narcotics Anonymous, Phenomenological, Psychiatric disorder, Recovery, Substance-related Disorder, 12-Step, Self-Help Group, Recovery.**

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Chapter 1: Introduction

1.1: Contextualising the problem:

Addiction is an age old problem that is experienced universally (Degenhardt & Hall, 2012). Substance-related problems are the cause of enormous societal costs and are among the leading causes of death in industrialised countries (Forray & Sofuoglu, 2012; Krampe et al, 2006; Vega et al, 2002.). Until the mid 1960's the subject of addiction was relegated to the status of a minor topic in the psychological literature and even recently discussions pertaining to addiction have largely been characterised by their paucity (Johnson, 1993). Similarly, biological and genetic theories of alcoholism have not been able to provide a precise understanding of the aetiology of addiction. Even though modest correlations have been found between drug intake and neural activation, biology alone has not been able to explain phenomena such as gambling addiction or a desire for excessive sexual behaviour (Graham & Glickauf-Hughes, 1992; Zintzaras, Stefanidas, Santos & Vidal, 2006).

These seemingly anomalous conclusions concerning a demonstrable aetiology for substance-dependence and/or addiction and the possibility of a disease syndrome as proposed by medical models of alcoholism lie in stark contrast to the ever expanding panoply of 12-step self-help groups (SHGs) which are currently the most popular mutual self-help groups in America and have occupied this status for some time (Merlo & Gold, 2008). These groups subscribe to the disease model that attributes the disorder to the individuals' biology (Alcoholics Anonymous, 2001; Johnson, 1993; Narcotics Anonymous, 2008). Despite the apparent popularity both locally and internationally of 12-step SHG's, which have been supported by extensive empirical research based on both clinical populations and the available literature, the disease concept of addiction is generally in disfavour among clinicians working in the mental health system (Grant, Gorelick , Potenza & Weinstein, 2010).

Findings from the South African Community Epidemiology Network on Drug Use (SACENDU) project suggest that the use of alcohol and other drugs (AODs) by South African adolescent's places a burden on the health, social welfare, and criminal justice systems of the country (Parry et al, 2004). Since an estimated 44.2% of the South African drug rehabilitation population were 20 years old or younger in 1998, the use of AOD's by this sector of the

population is a cause for concern due to its potential impact on the socio-economic development of the country (Parry et al, 2004; Steyn et al,2008). It is estimated that one in four high school students report past month binge-drinking. Finally, substance abuse has been implicated in approximately 50% of diagnoses of mental disorders (Ure, 2009). In light of the significant human and social costs, substance abuse and its prevention is a key psychosocial priority in South Africa.

The severity of substance-related problems in South Africa is further complicated by a combination of factors. These factors include the absence of consensus frameworks for conceptualising and treating substance-related disorders. The COD framework has demonstrated potential in the endeavour to provide better forms of treatment and assistance to those suffering from substance-related problems (Fabricus et al, 2008). Specifically, the COD framework for conceptualising substance-related disorders accommodates for the wide range of co-occurring psychopathology evidenced in individuals seeking treatment from substance-related problems. Not only does the COD framework allow practitioners working in the substance-related field and the mental health field to treat individuals with complex forms of CODs, but, the COD framework also helps practitioners to discriminate between those individuals who are more suited for mental health treatment and those individuals who are more suited for substance related treatment.

South Africa's relationship with substances is complex, and is linked to both the political and socio-economic history of the country (Schneider et al, 2007). In the apartheid years (from around the 1940's to 1994) many black families lived under the poverty line. In order to supplement or provide household income, many black women took to working in the informal sector, becoming laundry women, prostitutes and beer brewers. The lack of formal entertainment and amenities in suburban South Africa gave birth to a colourful public drinking culture, which remains today. Similarly, in the Western Cape wine regions, the workers on the wine-producing farms were provided with alcohol instead of wages. As recently as 1998, some farms in the area still provided their workers with alcohol as part of their conditions of service (Ure, 2009). There are also racial differences in the substances chosen by substance abusers in South Africa at present. These examples demonstrate the

oppressive nature that substance-misuse can exert upon certain people and communities (Schneider et al, 2007).

Current research indicates that programmes in South Africa that are available for substance-related disorders are not producing acceptable rates of recovery (Fabricus, Langa & Wilson, 2008). This is partially due to the current lack of consensus in the addiction field regarding evidence-based practices (ESBs). For this reason, the optimal processes for disseminating knowledge on empirically based interventions have not been identified (Edwards & Rawson, 2010). This fact is exemplified by research initiatives such as the Drug Abuse Treatment Outcome Study (DATOS), in which roughly half of all the subjects were readmissions to treatment. Slightly more than half (54%) of them relapsed within two years and 44% returned to treatment within 3 years (McLellan, 2005).

Similarly, research examining normative and pathological personality traits and characteristics of the dynamic relationship between personality and substance-use disorders has yielded multi-directional results, with some arguing that substance-abuse alters personality while others posit that pre-morbid personality disorders influence the development of substance-use disorders (Hopwood et al. 2011).

People with CODs are not homogeneous. In the context of this study, homogeneity refers to a set of symptoms resulting from a disorder that can be treated in the same way. Therefore, people with CODs require different and often times more comprehensive forms of treatment so that the underlying disorder can be dealt with (Brady & Sinha, 2005). Unfortunately, substance-related treatments are not yet integrated in South Africa to the extent that individuals seeking treatment for a substance-related disorder are required to independently seek supplementary care for other psychiatric conditions (Ziedonis, 2004).

Research that is available on CODs has focused primarily on the prevalence of these disorders in populations of people receiving substance-related treatment. There has also been a large body of research created in relation to how these disorders should be defined. However, research that explores the factors that facilitate and continue to maintain recovery from these disorders is not clear. Owing to a wide panoply of systemic disjuncture's including the rift that exists between the psychiatric field and substance-related treatment field; defining what actually constitutes recovery has proven to be a

formidable task with each of these treatment frameworks employing separate strategies to help individuals suffering from these disorders (Fabricus et al, 2008). In conclusion, the high prevalence of CODs in people attending substance-related treatment centres, the complex and varied presentation that these individuals have in a clinical setting and the high rate of treatment failures with these individuals indicate the extent of the need for the systemic study of how both people recover from CODs and substance-related disorders and continue to progress in a relative state of health, despite the challenges that they are faced with (Ralph, 2000).

1.2: Research aims

This research had a dual focus. It aimed to explore the way in which people with CODs and substance-related disorders have managed to reach a state of full recovery. This exploration will include an account of what has worked for the participants in terms of therapeutic aids and processes and what has not been beneficial to them. So, what the participants felt to be necessary in achieving recovery constituted the primary focus of this study. The way in which participants conceptualise their own pathology is also helpful in providing more information on the types of experiences that these people undergo and, ultimately, more information on CODs. This study also focuses on understanding the factors that are detrimental to recovery. This will constitute the second aim of this study. Essentially this research seeks to describe the processes that these individuals have followed in order to achieve a state of full recovery.

1.3: Rationale

The majority of the treatments that are available for substance-related disorders follow a 12-step approach (Weiss et al, 2007). This treatment model considers the substance-related disorder to be the primary disorder and assumes that the resolution of the substance-related disorder will lead to remission in other psychiatric problems (Pettinati, O'Brien & Dundon, 2013).

Research that has explored substance-related disorders and the various treatments that are available for them have documented significant rates of failure for people seeking treatment for substance-related problems (Fabricus et al, 2008; McGovern, Xie, Segal,

Siembab & Drake, 2006). Thus, recent years have evidenced an increasing interest in the reasons as to why these treatment programmes are not producing better outcomes.

Research into the field of CODs has been particularly credible as an hypothesis that accounts for the significant rate of treatment failures and subsequent re-admissions; with multiple studies confirming that anywhere between 50%-90% of people seeking treatment for substance-related problems and/or disorders suffer from one or multiple CODs (Drake et al, 1998; Fabricus et al, 2008; Kessler et al, 1996; McGovern et al, 2006).

Although there is now consensus that people seeking treatment for substance-related disorders frequently present with co-occurring psychiatric disorders, several research initiatives indicating the high prevalence of CODs have highlighted the need for more training in this area. However, at the clinical level, training in this particular area has been rated as among the lowest in perceived clinical adequacy (McGovern et al, 2006).

CODs have therefore been proposed as a leading cause of treatment failure and relapse among people who receive treatment in substance-related treatment facilities. Although there are several salient issues that pertain to the successful treatment of people suffering from CODs, one of the most challenging aspects of treating these disorders is their complex presentation in clinical settings.

More simply phrased, people with CODs are not homogeneous (Flynn & Brown, 2008). This means that people with CODs do not ordinarily derive the same perceived benefits from the standard 12-step treatment protocols that have already been mentioned. It also means that people with very severe CODs are more susceptible to a much a broader range of adverse consequences in comparison to individuals who suffer from less severe psychopathology. Finally, the lack of consensus on what it means to be afflicted with a COD places added pressure and responsibility on these people to take responsibility for their other psychiatric disorder/s that accompany their substance-related disorder.

For this reason, people with various CODs and/or combinations of disorders often require different forms of assistance. An example of a modified treatment approach is assertive community treatments (ACTs) that are designed to facilitate services in the patient's living environment on a 24-hour basis, with practitioners taking responsibility for a group of patients (Kessler et al, 1996). In light of the high prevalence of these disorders, it is alarming

to consider that there have been practically no attempts to research CODs through specifically qualitative methods. Because this research area has received very little qualitative attention, no widely accepted frameworks are available to help understand and conceptualise these disorders as opposed to the large number of frameworks that exist for many other kinds of disorders.

The term "CODs" is not a formal diagnosable disorder and therefore neither the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) or the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) can make a diagnosis of a COD (Fabricus et al, 2008). This research can begin to address this problem. With more qualitative research into CODs, future diagnostic systems, including later versions of the DSM and the ICD, could include CODs as diagnosable disorders.

Including CODs as diagnosable disorders in manual that are consider relevant to practitioners working in the field of substance-abuse may prove integral to improving treatment for these people. For example, one of the many positive consequences that incorporating CODs into diagnostic manuals would yield, would be to extend complex knowledge of these disorders to practitioners working in both the mental health field and the substance-abuse field. Finally, developing insight into the various manifestations that CODs have as well as expanding knowledge into the therapeutic aids that have been helpful or detrimental to people with CODs can greatly contribute to developing better forms of treatment for these people and for substance-related treatments in general.

1.4: Structure of the thesis: Summary

Chapter 1: This chapter discusses both the objectives of the study and the reasons the study is important. It also in this chapter that the first mention is made of concepts that will later become focus points in this study.

Chapter 2: This chapter provides the theoretical basis for the study. The purpose of this literature review is to critically examine all of the areas that are considered relevant to understanding the COD phenomenon substance-related disorders. In order to demonstrate the complexity of the COD phenomenon and substance related phenomena and to describe it as clearly as possible, several related areas have been drawn into this section. Special attention is given to the construct of CODs, which is defined in an in-depth manner.

Additionally, some of the key debates considered integral to understanding this (the COD) phenomenon better, have been included. This literature review involves several fairly extensive discussions regarding phenomenon that are related to the COD construct. These phenomena range from significant events in the history of psychiatric diagnosis to definition related issues concerning substance-related disorders, CODs and recovery. Discussions regarding the self-help groups of AA and NA are also included in terms of the frameworks that these fellowships utilise to interpret substance-related phenomena. The structure and processes that take place in these fellowships are also discussed. The literature review concludes with a discussion regarding Edward Khantzians self-medication hypothesis, which, in this study, is considered a critical framework for interpreting CODs and other substance-related phenomenon. Importantly, this hypothesis (now considered a theory) has psychoanalytic origins and precursors to certain of the constructs that are later used in thesis to understand the findings. A large focus is placed on CODs as it is important to acknowledge that reference to the presence of COD in an individual is not always made and so a greater focus on CODs gives flesh to findings that would otherwise be theoretical. For example, in this chapter the wide range of symptoms and challenges that characterise the lives of people suffering from CODs was discussed and the relationship between these symptoms and having a COD was discussed. However, in the findings section although the appropriate life experiences were supported by the corresponding authors, reference to the existence and action of a COD is not always made and only reference to the substance-related disorder is made. This is because the data collected was extensive and the experience of having a COD can vary greatly. Thus, the findings are supported by research that is relevant to and demonstrates the specific aspect of the COD phenomenon and substance-related phenomenon that is being addressed.

Chapter 3: This chapter describes the methodology that was used in this study. Important characteristics of the participants are discussed including age, race and gender. The means through which the researcher gained access to this sample is also elaborated on. This chapter concludes with a discussion on ethics and the reflexivity of the researcher.

Chapter 4: This chapter discusses the key findings derived from the interview process with the participants. As the findings were extensive, the chapter is sub-divided into three major sections, each of which constitutes a major section or sub-chapter of its own. The first major

section is entitled The meaning of suffering in substance-related disorders'. Broadly, this major section discusses the various consequences that stem from living with an untreated COD and a substance-related disorder. Gila Chens' spiritual framework of primary and secondary suffering are used to describe important events and processes that lead to the eventual arrest of the substance-related disorder.

The second major section is entitled A shift in trajectory. This section deals with the point at which the participants used in this study became abstinent. This section also discusses the ways in which this may have occurred and deals with certain of the changes that accompany the early recovery period.

The final major section is entitled Die Soegenden for reasons that are later explained. Briefly, this sub-chapter deals with periods of longer-term recovery from CODs and discusses characteristics that are associated with longer-term recovery from CODs. It emphasises both the therapeutic aids that further propelled the participants towards greater levels of health as well as those factors that were perceived by the participants as detrimental or threatening to their processes of recovery.

Chapter 5: This last chapter provides an overview of the key findings in the study. It also discusses the strengths and limitations of the research and the recommendations for future research.

Chapter 2: Literature review

The COD phenomenon is complex and therefore requires discussion of the following areas are discussed:

1. A brief history of psychiatric diagnosis
2. Addiction and substance-related definitions
3. The DSM-V
4. CODs
5. Substance-induced symptoms
6. Rehabilitation and recovery
7. The Disease Concept and 12-Step rehabilitation programs
8. Double trouble in Recovery self-help groups
9. The Four Quadrant Model
10. Theoretical views of CODs

2.1: A Brief History of Psychiatric Diagnosis

The Diagnostic and Statistical Manual 4th edition (DSM-IV) has been translated into over 20 languages and is a source that is referred to by clinicians and practitioners working in many different fields. It has also become a resource for policy makers, criminal courts and third-party reimbursement entities (Kawa & Giordano, 2012). The DSM has many uses, some of which include providing a common language for clinicians, a resource for researchers and it attempts to bridge the gap between the clinical and research interface (Frances & Widiger, 2012). Given the influence that such a diagnostic tool possesses, it is helpful to critically engage with some of the significant advancements in its history. This in turn will help to contextualise certain areas that are relevant to this study.

In the field of addiction treatment there has been a longstanding tendency to negate inferential and dynamic understandings of substance-related disorders to the end of satisfying simple descriptive diagnosis and verifiable criteria. This trend is exemplified by

efforts to treat substance-related disorders through the application of intensive short-term behavioural treatments to a range of substance-related behaviours (Johnson, 1999). The short-term treatment of substance related disorders would appear to be counter-intuitive as the predominant framework used for conceptualising substance-related disorders posits that substance-related disorders are in fact part of an ongoing and progressive disease that requires ongoing treatment (Shaffer, LaPlante, LaBrie, Kidman, Donato & Stanton, 2004). This is a matter that will be explored in greater depth in later sections.

The first attempts to formally classify psychopathology in the United States were undertaken during the early 19th century. To a large extent, such efforts were undertaken through collections of demographic data by the Bureau of the Census. The findings were primarily intended for mental health policies for regulating the treatment of the institutionalised mentally ill; rather than for diagnostic purposes (Kawa & Giordano, 2012).

Uncertainty regarding the nature and causes of psychopathology led to attempts to create a systematic body of knowledge capable of unifying these varying conceptions in a single manual. The first examples of this can be found in the *Statistical Manual for Use of Institutions for the Insane*- the predecessor of the *Diagnostic and Statistical Manual of Mental Disorders* series. This volume contained 22 diagnostic categories, most of which were psychotic conditions associated with a presumed somatic aetiology. These diagnostic categories' reflected Kraeplanean orientations, which were the dominant framework at the time and related abnormal behaviour to organic brain dysfunctions.

Changing conceptualisations of mental illness and the increasing numbers of clientele led to the creation of the *Diagnostic and Statistical Manual* (DSM-1). This manual was officially released in 1952. It contained 102 broad categories of mental disorders that shared psychodynamic aetiological explanations. These conditions were sub-divided into groups including 1) conditions which were assumed to be caused by organic brain dysfunction and 2) conditions presumed to be the result of socio-environmental stressors.

While held in high regard by its authors, the DSM-1 actually had little influence on psychiatric practice. However the DSM-1 contributed towards the trend of increasingly standardised categories of mental disorders. To compensate for shortcomings in the first edition of *the Diagnostic and Statistical Manual*, the second edition of the *Diagnostic and*

Statistical Manual of Mental Disorders (DSM-II) was published in 1968. This manual was to a large extent, reflective of psycho-dynamic understandings of mental illness.

The 1960's presented many challenges to the concept of mental illness. Several assertions by major theorists such as Thomas Szasz and Erving Goffman at the time increased the need of psychiatry to create a unified and reliable body of knowledge (Kawa & Giordano, 2012). The two most significant changes in the DSM-II was 1) a broadening or expansion of the previous definitions of mental illness and 2) an increase in systemic categorisation in mental illness. This first change embodied the need to include milder forms of mental illness and served to significantly enlarge the way that mental illness was conceptualised. The second was an increased systematic categorisation and specifity that suggested a return to the Kraeplanian tradition. An example of this was the addition of 8 new alcoholic brain syndromes that were now included in the DSM-II as well as the understanding that schizophrenia was (1) distinguishable from manic (bipolar) psychosis and (2) the notion that the various manifestations of the condition(schizophrenia) were actually variations of dementia Praecox (Austin & Burke, 2009; Jordaan, 2009).

Like the DSM-I, the DSM-II presented a psychosocial view of psychiatric illness. Within this framework, psychiatric illnesses were understood as reactions to stresses of everyday living rather than discrete entities that could easily be demarcated from one another or even from normal behaviour and experience (Austin & Burke, 2009). The intentions of the DSM-I and DSM-II are clearly demonstrated by the emphasis that was placed on the meaning of symptoms. Many view this as the essence of psychodynamic psychotherapy; that is to understand the symptom rather than to manipulate the symptom directly (Wilson, 1993). From this perspective, naming a disease was of much less significance than understanding the underlying psychic conflicts and reactions that gave rise to symptoms (Austin & Burke, 2009).It was also in these two editions of the DSM that alcoholism and drug addiction were classified under the category of personality disorder (Ball, 2005).

Thus the DSM-I was heavily influenced by psychoanalytic theory as well as an emphasis on individual failures of adaption to biological or psychosocial stressors as the cause of psychiatric illness (Austin & Burke, 2009). This understanding and strategy of classification informed the DSM-I and DSM-II but it was radically altered with publication of the DSM-III (Wilson, 1993). Drug addictions, which were previously considered under the broad

category of personality disorder, were now disentangled as was evidenced by their relocation on a separate axis (Ball, 2005).

One of the central criticisms levelled against the psychosocial model was that it did not clearly delineate the boundary between mental illness and mental health and thus diagnosis based on this model were considered questionable (Wilson, 1993). Continued doubt concerning the lack of clarity in the diagnosis of mental health led to the belief during the 1960's that psychology practices as compared to other medical services had less clarity in terms of uniformity of terminology concerning mental diagnoses as well as the types of facilities providing care (Wilson, 1993). The existing lack of clarity regarding the boundary between mental health and mental illness was further reinforced by an influential paper authored by Robert Spitzer and Joseph L. Fleiss, which argued that the DSM-II was not a reliable diagnostic tool as evidenced by the fact that psychiatrists were rarely in agreement when diagnosing patients with similar conditions (Kawa & Giordano, 2012). Other events such as the controversy over the disease status of homosexuality as well as the Rosenham study demonstrated that there should be concern about the reliability of psychiatric assessment and the danger of misdiagnosis (Wilson, 1993). These concerns were primarily dealt with through an attempt to bring methods that were viewed as successful in medicine to the field of psychiatry. This approach is referred to as Neo-Kraeplenian (Galatzer-Levy & Galatzer-Levy, 2007).

World War II is also a significant factor in the bringing together of different schools of psychiatric thinking including the Freudian theory of personality and intrapsychic conflict, as well as the more environmentally orientated mental hygiene movement influenced by Meyerian psychobiology (Wilson, 1993). Thus changes in intellectual thinking shared parallels with changes in institutional geography of psychiatry at the time. Asylum psychiatry and the Kraeplenian model on which it was based fell into decline and the field became dominated by private practitioners and hospital and community psychologists who began to apply a now more synthetic model from the ideas of Freud and Meyer (Wilson, 1993). Beyond obvious limitations in ability to explain mental illness, compounding this issue was the apparent lack of progress in research that this model generated. Thus shortcomings in this model later led psychiatrists to a return to the medical model (McWilliams, 2010; Wilson, 1993).

It is now consensus that the publication of the third edition of the *Diagnostic and Statistical Manua*l (DSM-III) represented a major change in the way that psychopathology was, and to a great extent is still viewed (Wilson, 1993). McWilliams (2010) argues that this change was embodied by a 'paradigm shift' from inferential psychiatry to descriptive psychiatry. This change is observable across a broad spectrum of mental illnesses and has had several far-reaching consequences. In many ways, the decision to publish the DSM-III can be viewed in terms of a response to a crisis in legitimacy for the profession of psychiatry and clinical psychology (Galatzer-Levy & Galatzer-Levy, 2007). This crisis was primarily orientated around the field of psychiatry and of clinical psychologies struggle to define themselves as a profession and achieve the status of an empirical discipline (Wilson, 1993).

The DSM-III divides mental disorders into separate categories. In this way psychiatrists that operate from within this paradigm do not recognise a continuum of illness but rather treat certain states as qualitatively distinct from one another (Galatzer-Levy & Galatzer-Levy, 2007; McWilliams, 1994). Distinctions are made between many categories of disorders on the basis of one manifestation that may often be peripheral to the potential etiologic consideration. The categories contained within the DSM-III are broad and in many instances only specified by the numerous possible combinations of symptoms. Furthermore, many of the categories overlap in symptomology and/or typically occur together (Austin & Burke, 2009).

The DSM-III relies on standardised knowledge rather than clinical expertise as its statistical knowledge is based on groups rather than individuals (Wilson, 1993). As a result pathology is viewed concretely in that there is an assumption about the permanence of pathological structures or defects in patients' personalities. These assumptions have shaped clinicians' views of pathology and limited their recognition of deeper, more personal difficulties in working with certain patients. This is particularly evident in the way that the DSM-III omits concepts such as defence (McWilliams, 2010). Further efforts have been made for diagnoses to be purely descriptive although it is suggested that certain disorders, particularly personality disorders, require more inference on the part of the observer (Kawa & Giordano, 2012).

2.2: Addiction

There have been numerous attempts to define addictions and/or pathological substance abuse. These definitions have arisen in many contexts and in many academic fields. After conducting a thorough literature review the researcher felt that a definition that accounted for all types of addictions in all of their manifestations would be superfluous and extremely complicated. Instead the researcher looked to some general themes against which addiction is defined. However, one factor that is considered critical to understanding certain of the assertions put forward in this study is the assertion that every individual who is described as 'addicted' and/or 'dependant' on a substance/s does in fact suffer from CODs. Making this assertion sets up the COD concept as a framework to view substance-related phenomena rather than simply a concept. The basis of this framework is to view the substance-related problem as the external manifestation of internal psychiatric distress and pathology. Viewing substance-related disorders in this way is further complicated by the fact that other kinds of psychiatric disorders can exist simultaneously which serve impede remission from a substance-related disorder.

Wurmser. (1947) posited that addiction is defined according to socio-legal criteria. Substance-abuse therefore refers to a pattern, usually of self-administration that deviates from important medical and social norms within a given culture. Given the breadth of change that is characteristic of how mental illness has been defined over the years, it becomes obvious to see that any attempt at defining pathological substance use would be like, "enquiring into the aetiology of fever" (Wurmser, 1947.p.820). Although excluding various methods of conceptualising substance-related disorders sets up substance-related and/or addiction-related phenomena as undefinable and nebulous, it also demonstrates the complexity of substance-related disorders. Where Wurmser. (1947) used the analogy (of fever) to illustrate why one definition of addiction was unattainable because in this instance, fever can have multiple causes, it is precisely this aspect of addictions that is taken into account by the CODs framework. More specifically the theory of CODs suggests that and accounts for the possibility that a substance-related disorder and/or addiction can have multiple causes.

In the first and second editions of *the Diagnostic and Statistical Manuals*, alcoholism and drug addiction were classified under the category of personality disorder (Ball, 2005). As has been discussed, this changed with the publication of the DSM-III, which separated substance-use disorders from personality disorders through their relocation on a separate axis (Ball, 2005). One of the most significant advances in the DSM-IV approach to CODs was the distinction between primary or independent disorders, and substance-induced disorders. This distinction allowed clinicians to determine when a mental disorder could be considered independent of substance-use. It recognised that some psychiatric syndromes occurring only during substance use might have clinical implications for prognosis and treatment (Ball, 2005; Nunes & Rounsaville, 2006). The disentanglement of personality from addiction seemed consistent with the failure during the preceding two decades to identify a single, overarching addictive personality type (Ball, 2005; Sutker & Allain, 1988).

At the same time as the publication of the DSM-III, Woody and Blaine (1979, as cited in Flynn & Brown, 2008) drew attention to literature describing the relationship between mental health problems and substance-use disorders in substance-abuse treatment clients. Recognising these as separate disorders, research on the co-occurrence of substance use and personality disorders became relevant for understanding the prevalence and prognostic significance in substance-related disorders (Ball, 2005).

Given the influence that the DSM possesses both within the psychiatric community and society it is useful to critically engage with certain aspects of this framework. In terms of this study, substance-dependence was evidenced in all of the participants used in this study. This framework is also the most widely used framework for diagnosing disorders in substance-related treatment centres. However, further in this chapter, other modes of understanding the COD phenomenon are discussed.

The DSM-IV-TR does not use the term addiction but it refers to a state known as substance-dependency (APA, 2000). This diagnosis is determined by the presence of at least three of seven dependence criteria as listed below. If at least three dependence criteria are not met then a diagnosis of substance-abuse is made, provided that at least one substance-abuse criterion is met (Hasin et al, 2013). While the DSM has been praised for standardising

psychiatric diagnostic categories and criteria, it has also generated controversy and criticism. Critics, including the National Institute of Mental Health as well as proponents of psycho-analytically orientated forms of therapy, argue that the DSM represents an unscientific and subjective system (McWilliams, 2010). There are several ongoing issues concerning the validity and reliability of the diagnostic categories including the reliance on superficial symptoms, the use of artificial dividing lines between categories of mental disorders which deviate from 'normality' in a concrete manner ,cultural bias and the medicalisation of human distress (McWilliams,2010). As will be taken up later in this chapter, what is important to acknowledge here is that although the DSM-IV sets up diagnosis of substance-related disorders in order of severity, the participants in this study did not recognise different levels of severity for a substance-related disorders and only recognise a distinct state referred to as "addiction" and "alcoholism" which are viewed as irreversible. The implications of conceptualizing addiction as distinct disorder that is irreversible are compared with other frameworks, namely the DSM framework and psychodynamic schools of thinking.

The criteria for substance-dependency according to the DSM-IV-TR are as follows:

> A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring within a 12-month period:
>
> 1) Tolerance, as defined by either of the following:
>
> > a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
> > b) Markedly diminished effect with continued use of the same amount of the substance.
>
> 2) Withdrawal, as manifested by either of the following:

a) The characteristic withdrawal syndrome for the substance (refer to the DSM-IV-TR, Criteria A and B of the criteria sets for withdrawal from the specific substance).

b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms).

3) The substance is often taken in larger amounts or over a longer period than was intended.

4) There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5) A great deal of time is spent in activities necessary to obtain the substances (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.

6) Important social, occupational, or recreational activities are given up or reduced because of substance use.

7) The substance use is continued despite knowledge of having persistent or recurrent physical or mental health problems that are likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (APA 2000,p.197).

One of the foremost concerns that is apparent from looking at this framework is that an actual diagnosis is determined by the presence or absence of symptoms. The problem is therefore complex due to the following reasons. Symptoms help practitioners working in the substance-related field to determine whether there is a substance-related disorder present and to determine the severity of the substance-related disorder. Outside of this context, it is less clear whether these symptoms are sufficient to warrant a diagnosis

because anyone who uses substances can at various times meet certain of these criteria without necessarily being addicted and/or dependent on a substance. For example, the DSM-IV-TR framework infers that the two diagnoses of abuse and dependence should be viewed hierarchically with dependence describing a group of people who are considered to have a more severe substance-related disorder than those who are diagnosed with only substance abuse (Hasin et al, 2013). However, both of these categories are considered maladaptive to the extent that they both cause clinically significant distress or impairment. Owing to the apparent similarities in these terms the meaning of "abuse" and "dependence", the distinction between substance-abuse and substance-dependence is often unclear, with the two terms sometimes being used interchangeably (Sacks, Chandler & Gonzales, 2008; Ure, 2009). Similarly, the terms "addiction" and "substance-dependence" are often thought to refer to the same phenomenon.

Many treatment centres continue to operate according to this criteria because in many instances admission criteria to substance-related treatment centres are based primarily on observable symptoms that are attributed to the substance-related problem. Thus, substance-related disorders are treated as the primary disorder in substance-related treatment centres. In contrast, individuals attending either psychiatric forms of treatment or therapy with therapists in private practice are not necessarily treated from the presupposition that the substance-related disorder is the primary disorder. In contrast, treatment in psychiatric treatments are often less directive, allowing for more emphasis to be placed on the client determining what symptoms deserve attention. Consequently, there has been debate concerning:

(1) Whether all of these terms refer to the same phenomenon.

(2) Whether the terms "abuse" and "dependence" and addiction, denote the same level of severity, as many people can have addictions without necessarily being considered mentally ill (Fabricus et al, 2008).

The DSM-IV-TR itself is also a theoretically neutral framework. Therefore it does not employ specific theories to help understand and interpret substance-related pathology (Austin &

Burke, 2009). Thus these criteria do not offer any aetiological considerations and the reasons as to why an individual may abuse substances to the extent that they require a form of rehabilitation are not provided. Moreover, once arriving in a treatment setting, similar interventions are applied to all individuals, regardless of potential causal factors in the development of the substance-related disorder. One of the negative consequences of applying blanket treatments to clients attending substance-related treatment centres is an over simplification of problems in the individuals life.

A primary reason that aetiological considerations are relevant to this research and more specifically the CODs phenomenon is because the history of the substance-related problem, including events that contributed to the development of the substance-related disorder, as well as those factors that served to further compound the problem, can have important prognostic implications (McWilliams, 2010). For example, the participants in this study were not familiar with the term "substance-dependence" and even the term substance-abuse was generally understood as a state equivalent to addiction. Rather than viewing different forms of substance-use as existing along a continuum in terms of severity, as the DSM-IV criteria would suggest, the participants did to a large extent view the world as existing in two categories, namely addicts and non-addicts, the latter of which they often referred to as 'normal-people'. Thus the DSM-IV-TR is that it does not describe any of the internal or psychological mechanisms of the individual that may lead to later substance-abuse or dependency. The question then of, 'who is an addict'? and/or 'what is an addict?-as understood in terms of internal psychological mechanisms at work', is not clearly defined in this framework.

2.3: The DSM-V

The 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) is the first major revision of the DSM in 30 years. Among several other important goals, the DSM-V represents a continued effort to make the DSM and ICD compatible (Kawa & Giordano, 2012). Several basic criticisms have been leveled against this framework. The first captures an ongoing concern regarding the movement towards a medical model of illness. A related concern is that the DSM-V represents a pathology based model rather than a strengths based model, often serving to further pathologise individuals with mental disorders. Furthermore, the DSM-V has not received the desired level of clinical support from clinical

trials. Finally, practitioners using this framework run the risk of over diagnosing and over prescribing medications.

As with earlier editions of the *Diagnostic and Statistical Manuals,* the DSM offers a common language and standardized criteria for the classification of mental disorders. It is used and relied upon, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, the legal system, and policy makers together with alternatives such as the ICD, which is produced by the World Health Organization (WHO)(Widiger & Samuel,2005).

The ICD-10 was created by the World Health Organization (WHO). It is the other commonly used manual for mental disorders. It is distinguished from the DSM in that it covers health as a whole (McWilliams, 2010). While the DSM is the official diagnostic system for mental disorders in the United States of America, the ICD is used more widely in Europe and other parts of the world (Hasin et al, 2013).

The fifth edition of the DSM contains extensively revised diagnoses and, in some cases, broadens diagnostic definitions while narrowing definitions in other cases. The DSM-V is the first major edition of the manual in twenty years, and substance -abuse and substance-dependence from DSM-IV-TR have been combined into a single substance-use disorder specific to each substance of abuse within a new "addictions and related disorders" category. "Recurrent legal problems" was deleted and "craving or a strong desire or urge to use a substance" was added to the criteria. The threshold of the number of criteria that must be met was also changed. Severity from mild to severe is based on the number of criteria endorsed. There were other additions such as the criteria for cannabis and caffeine withdrawal. New specifiers were added for early and sustained remission along with new specifiers for "in a controlled environment" and "on maintenance therapy"(Hasin et al, 2013).

A factor that has led to further confusion, specifically with regards to substance-related disorders, is that the DSM-V has given up the term “addiction” and now uses only the term “dependence” (O’Brian, 2011). Presently abuse is seen as an early form or less severe form of a disease/disorder characterised with the dependence criteria. However, the APA's “dependence”, as noted above, does not necessarily mean that physiological dependence is

present but rather that a disease state is present; one that most would likely refer to as an addicted state. Because the term “dependence” shares dual meanings where, for example, “dependence” can simply refer to the physiological mechanism that occurs when medications that directly affect the central nervous system are used and then abruptly discontinued, resulting in a state of withdrawal that any individual is susceptible to. It is difficult to clarify what is meant by being dependent (O’Brien, 2011). In light of these concerns it has been argued that the available terminology has led to confusion, both within the medical community and with the general public (Hasin et al, 2013). Thus the fifth edition of the DSM is likely to have this terminology revisited yet again.

2.4: Co-occurring disorders

There are many ways to define addiction. Examples include the disease-concept, the DSM-IV-TR framework and the self-medication hypothesis. These three act as explanatory frameworks that describe different aspects of substance-related disorders. The CODs phenomenon is no different in this respect. However, the term COD itself is widely misunderstood and very often equated with terms that are assumed to be its equivalent. These terms include “dual-diagnosis” and/or “comorbid disorders”. In relation to this study, the term COD should be understood in terms of a framework that is used to describe specifically substance-related pathology.

The term “CODs” is a blanket description, covering all types of substance abuse and mental health disorders and all the levels of severity of those disorders (Flynn & Brown, 2008).However, CODs are not limited to only two disorders as its predecessing term, “dual diagnoses” would suggest**.** The term “CODs” allows for the possibility that a client may have more than one substance-related disorder and more than one psychiatric disorder (Sacks et al, 2008). The two or more diagnoses that are made need to be made independently of one another and cannot simply be a cluster of symptoms resulting from one disorder (Fabricus et al, 2008)**.**

The term “CODs” has remained contentious because it is not always clear what the term refers to. Despite the apparent use of the COD concept, it has been argued that the term itself lacks specificity in terms of both the diagnostic category, and the severity of the disorder (Flynn & Brown, 2008). The term itself arose from the apparent inadequacy of the

term dual diagnosis that by definition assumed that a client had only two disorders. Furthermore, the term “COD” is not a diagnosable disorder that conforms to a set of causal relationships as the disease concept would suggest, for example (Flynn & Brown, 2008; Singer et al, 1999).

In the context of this research all of the participants had initially received a diagnosis of substance-dependence. However, none of the participants referred to the term substance-dependence. Rather they used the term “addiction” to refer to an irreversible state that could be arrested. However, control over the various substances that they (the participants) used was not possible.

Therefore, someone suffering from schizophrenia and major depressive disorder (MDD) would not be considered to have CODs by health professionals as there is no substance-related disorder present. However, people with a substance-related disorder and another psychiatric disorder are considered to have a COD. In spite of the theoretical misgivings that are characteristic of many psychological constructs in their early stages of development, the apparent contentions that surround the COD construct are in fact indicative of the distinctions that are made in the health care profession between a medical and a psychological problem (Fabricus et al, 2008).

People with CODs are particularly susceptible to relapse because of the complex nature of their problems. However, this statement must be used and interpreted within the appropriate contexts. The reason that people with CODs are so susceptible to relapse is because anyone suffering from a substance-related disorder and thus a COD is subject to very complex problems in living. However, the degree to which this is the case must be considered in every situation because as has already been discussed, people with CODs are not a homogenous population. Therefore, the COD phenomenon can be viewed along a continuum with certain individuals remaining relatively functional despite having CODs whilst others are afflicted with more complex and severe CODs resulting in significant reductions in quality of life. However, research concerned with what the implications of living with these disorders can present to the life of an individual with CODs suggests at the most fundamental level, a greater substance-abuse and psychiatric symptom severity, an increased risk of depression, suicide, hospitalisation and rehospitalisation, repeated treatment admissions, over-use of medical care, employment and legal problems, inability

to manage finances, unstable housing and homelessness, victimisation or perpetration of abuse, and increased vulnerability to HIV infection (Colpaert,Maeyer,Broekaert & Vanderplasschen,2012;Drake et al, 1998). However, individuals suffering from less severe CODs may not be subject to these conditions and may only suffer some of these consequences. Equally, those people with CODs that are considered to be of a more severe nature would suffer a greater number of these negative life experiences.

A final point that is worth discussing and that has served to further complicate issues related to substance use is the fact that all of the mental disorders are consistently more strongly related to substance dependence (Kessler et al, 1996). This does not mean that having a psychiatric disorder immediately qualifies itself as having CODs; that is to say that an individual who has a psychiatric disorder does not necessarily also have another substance-related disorder. It merely suggests that there is a higher incidence of substance-related problems where psychiatric/psychological problems are present. Conversely, a more severe substance-related disorder is associated with a greater incidence of more severe psychological problems and/or disorders.

2.5: Addiction Recovery and Rehabilitation

It is difficult to define what exactly constitutes recovery from a mental disorder. Defining recovery has proven problematic in the treatment of substance-related disorders where the concept of recovery remains poorly understood. Interestingly, the term, “recovery” has almost exclusively been associated with 12-step recovery for an extended period in history. Accurate and appropriate definitions of,”recovery” are necessary because without them, the conditions for the best forms of treatment remain general and vague and therefore treatment interventions are often less effective because the goals are not always known (Laudet, 2007).

The disjuncture between the mental-health and substance-related treatment centres is partially responsible for this lack of clarity. These two systems have developed independently, each with its own administrative agencies. There are also significant philosophical differences between mental health and substance abuse providers, for example, biases against substance abuse clients taking psychiatric medication, which have contributed to and perpetuated systematic differences in approaches to their pathology.

These systems also utilise different conceptual models in defining what substance-dependency and related disorders are, with 12-step programs utilising a bio-medical model for treating substance dependency. (Trull, Kenneth, Minks-Brown, Durbin & Burr, 2000).

Historically, the mental health field has organised its services around the goal of, “partial recovery”, a term that is best applied to patterns of problem resolution marked by decreases in the frequency, duration and intensity of alcohol and substance related problems and an increase in the length and quality of periods of sobriety or decelerated use. However, there is no consensus definition of, “recovery” that is inclusive of those people suffering from CODs. In order to accommodate for those people suffering from CODs it has been proposed that the concept of recovery needs to be multi-dimensional (Drake, Xie, McHugo & Shumway, 2004). Because 12-step substance-abuse programs conceptualise recovery primarily in terms of abstinence from alcohol and other substances; people with additional psychiatric symptoms may experience difficulty in attaining the same range of benefits available to those suffering from only a single diagnostic disorder (White, 2007).

A useful working definition that illustrates some of the shortcomings of how recovery is defined specifically in substance-related treatment centres is the outcome expectations of substance-related rehabilitation. From this viewpoint, rehabilitation is best understood in terms of the expected outcome of addiction treatments. According to McLellan, Mckay, Forman, Cacciola and Kemp (2005) there are four outcome expectations:

1. Reduction of alcohol and drug use.
2. Increase in personal health.
3. Improvement in social function.
4. Reduction of threats to public health.

These aims are almost identical to treatments for other illnesses, including hypertension, asthma and diabetes. One difference is that addiction treatment is time limited; with hypertension, asthma or diabetes the intensity of medication or services is not measured in fixed amounts, nor is there a time limit. The reason, that is widely accepted, is that there are no cures for the conditions of hypertension, asthma and diabetes. Thus treatment for these

conditions is ongoing with a varying intensity of care and monitoring being provided and which is contingent on the severity of the symptoms (McLellan et al, 2005).

In line with this reasoning, the effectiveness of addiction treatment is largely measured by its ability to reduce the 'substance-related' problems, in particular the reduction of alcohol and drug abuse. These goals mirror the presenting symptoms of a substance-related disorder according to the DSM-IV criteria set out in the previous section. It is important to acknowledge that these goals are necessary in the treatment of a substance-related disorder, especially in the early phases of treatment.

However, these goals have not proven sufficient to achieve and maintain longer-term goals of improved personal health and social function. A dilemma pertinent to South Africa is that historically, patients with CODs have been treated in separate mental health and substance abuse systems where the full scope of the problem cannot be dealt with. Thus providing comprehensive and integrated forms of treatment is beginning to be recognised as one of the most prominent barriers to better forms of treatment for individuals with CODs.

Treatment so far, has been discussed in the context of in-patient treatment settings. However, varying forms of treatment for substance-related disorders are available in the form of 12-step fellowships such as Alcoholics Anonymous (AA) and their associated philosophy. Although not formally classified as such, these self-help groups (SHGs) are commonly equated with a form of treatment in substance-related treatment facilities. Some of the basic philosophies of these SHGs posit the existence of an ongoing and progressive illness, which results in a requirement for it's (the SHGs) continued presence. Participation in such SHGs very often continues throughout the entire lifespan (Dodes, 1990).

These social support networks constitute one of the ways in which mental health consumers have used to communicate to other consumers and non-consumers that recovery can and does take place. These support networks often include discussions regarding definitions of recovery and descriptions of the processes, support structures and activities that have enabled or enhance people who attend these SHGs recoveries (Weiss et al, 2007).

In an unpublished paper Ridgeway. (1999, as cited in Ralph. 2007) analysed a series of early consumer narratives in which he found the following common themes:

- Recovery is the re-awakening of hope after despair;
- Recovery is breaking through denial and achieving understanding and acceptance;
- Recovery is moving from withdrawal to engagement and active participation in life;
- Recovery is active coping rather than passive adjustment;
- Recovery means no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self;
- Recovery is a journey from alienation to purpose;
- Recovery is a complex journey;
- Recovery is not achieved alone-it involves support and partnership.

Although these points embody many interesting and valuable themes researchers and clinicians alike cannot remove themselves from the fact that across cultures, recovery from a mental disorder is defined in different ways. Consequently people admitted to treatment centres for psychological disorders are diagnosed and treated differently (El-Guebaly, 2012). Recovery from substance dependence is best defined in terms of a person's total relationship with psychoactive substances, rather than in relation to one single substance (White, 2007). Like rehabilitation the goal of abstinence can be helpful but does not necessarily guarantee that the other mental disorder/s will improve in the long term. However, it can be equally problematic to define recovery only in characterological terms as many substance-related treatments do (White, 2007). For example, 12 step programs attribute all forms of substance abuse to self-centredness,"Selfishness-self-centredness! That we think is at the root of our troubles" (Wilson, 1938, p.62).

Construing human suffering in a way that attributes psychological and emotional distress to moral shortcomings can serve to further pathologise the distress of the individual and deter those who would otherwise seek help from a professional treatment centre (Ahmed & Suffla, 2007). Because there is no consensus definition of "recovery" across all CODs there has been variability in reported outcomes in terms of the success that various treatment methods have yielded.

For example practitioners working in the substance-abuse field may claim success in treatment when the substance abuse disorder has been arrested; however those working in the mental health field may view substance-use in any form only as symptomatic of another psychiatric disorder. Thus the definition of what constitutes recovery needs to cover a broader scope of factors than is evidenced by the current literature on CODs (White, 2007).

Since community-based interventions have been advocated as particularly effective for delivering mental health services to people seeking help for substance-related problems; important concepts related to community psychology deserve discussion. Community psychology interventions describe a set of services within targeted individuals in their communities, often addressing problems in the home, school and neighbourhood contexts (ecological factors) in which they occur (Wagner, Tubman & Gil,2004). Community psychology represents a number of disciplines but primarily concerns itself with communities as its primary focus and always considers the individual in context (Naidoo, Duncan, Roos, Pillay & Bowman, 2007). School-based interventions are a specialised subset of community-based interventions, which have also grown increasingly popular over the past several decades.

The community psychology approach concerns itself with several principles and values including prevention and health promotion, holistic ecological analysis and interventions, a psychological sense of community, cultural relativity, socially responsive psychological praxis and socially relevant psychological praxis (Stevens, 2007).

Under the community psychology approach three other important approaches that exist within the community psychology framework, including the social action model, the mental health approach and the Public Health Model, are discussed in the findings section to help contextualise certain of the findings.

For example, the social action model embodies the notion of empowerment and argues that health cannot exist in the context of oppression. By arguing that health is not possible in the context of repression and domination, social action programmes address themselves to issues of finance, power, increasing resources, education and community development. Given that South Africa evidences the highest Gini coefficient in the world, that is the greatest difference in income between different income classes, tertiary intervention

programmes that include traditional counselling and treatment centres are not considered accessible and realistic services to offer communities in South Africa such as Alexandra or Diepkloof. Programmes aiming to help individuals suffering from CODs to attain a relative state of recovery, therefore, need to address and incorporate the expertise of local non-professionals as they rarely have the required resources to provide professional forms of treatment.

Substance-related disorders have an exacerbating effect on educational, financial and family network factors with many addicts presenting as completely financially unstable and unemployable as a result of the complex nature of their psychological disorder as well as the physical side-effects of pathological-drug use. Congruent with the social actions models' values of self-determination and empowerment, interventions based on the principles of this model, aim to create an environment in which community members themselves are responsible for one another's continued abstinence from harmful substances and support for one another. The role of the health professional using the social action model is to organise, activate, mobilise, empower and provide resources or make contacts that were not there before (Ahmed & Pretorius-Heuchert, 2001).

Empowerment in the context of recovery from a COD can take place through mediating structures including schools, neighbourhoods and voluntary organisations such as Thusong youth Centre in Alexandra Township. Implementing empowerment requires researchers to look at several diverse settings and focus on what people are doing to handle their own problems in order to learn how they do it. Applying interventions based on empowerment requires examining power relations and conflicting interests within communities. Once this is done, this information needs to be made public so that these solutions are available to other communities that need help. In this way, empowerment is a process or mechanism that helps people in communities gain mastery over their affairs (Rappaport, 1981; Rappaport, 1987; Seedat et al, 1988). Understanding empowerment is important because it creates broader requirements for determining what constitutes recovery from a psychological disorder.

2.6: Substance-induced Symptoms

One of the most significant advances in the DSM-IV approach to substance-related disorders is the distinction between primary or independent disorders, and substance-induced disorders. This distinction allows clinicians to determine when a mental disorder could be considered independent of substance use. Thus the DSM-IV acknowledges that some psychiatric syndromes occurring only during substance use might have clinical implications for prognosis and treatment (Ball, 2005; Nunes & Rounsaville, 2006).

A major obstacle in diagnosing co-occurring psychiatric conditions in substance abuse patients is the tendency of the abused substances to induce symptoms that are often indistinguishable from other independent disorders (Kadden,Kranzler & Rounsaville, 1995).The topic of substance-induced symptoms is complex because drug abuse, including alcohol and prescription drugs, can induce symptoms that resemble mental illness and can make it difficult to differentiate between substance-induced psychiatric symptoms, and pre-existing mental health problems.

Substance-induced psychiatric symptoms can occur in the intoxicated state as well as the withdrawal period. In some cases these substance-induced psychiatric disorders can persist long after detoxification, such as prolonged psychosis or depression after amphetamine or cocaine abuse (Zweben et al, 2004).

More often than not, psychiatric disorders among drug or alcohol abusers disappear with prolonged abstinence (Kadden et al, 1995; Singer, Kennedy & Kola, 1999). One of the primary reasons that it is important to have reliable diagnostic criteria that differentiate substance-induced symptoms from those that are clinically significant is that if clinically significant disorders are ignored, these disorders will have a direct impact on the recovery of an individual, with many potentially significant and negative consequences such as patient dropout or poor response to treatment among several other adverse consequences (Kadden et al, 1995).

In spite of such warnings Green et al. (2008) have argued that CODs very often go undetected and untreated in mental health settings, where the historical separation of mental health and substance-abuse programmes has resulted in a lack of knowledge about co-occurring disorders.

The longstanding tendency to treat the substance-related disorder as the primary disorder in the context of substance related treatments stems from the clinical perspective that treating the substance-related disorder will lead to the resolution of other psychiatric disorders, or that one disorder will be easier to treat if the other is in remission (Pettinati et al, 2013).Because resolving the matter of substance-induced symptoms is essential in carrying out an effective diagnosis, abstinence as the primary treatment goal remains the protocol for the majority of substance-related treatments (Flynn & Brown, 2008).

Substance-induced disorders are distinct from independent co-occurring mental disorders because all or most of the psychiatric symptoms are the direct result of substance use (Bruce et al, 2005). This is not to say that substance-induced disorders preclude CODs, only that the specific symptom cluster at a specific point is more likely the result of substance use, abuse, intoxication, or withdrawal rather than a fundamental mental illness.

These symptoms can range from mild anxiety and depression (as these are most common across all substances) to full-blown manic and other psychotic reactions which are less common (Bruce et al, 2005).In either case it is paramount to continue to evaluate the psychiatric symptoms and their relationship to abstinence or ongoing substance abuse over time (Sacks et al, 2008).

2.7: The Disease Concept of Addiction and 12-Step Self-Help Groups

During the 1940s & 1950s alcoholics were discouraged from gaining admission to psychiatric treatment settings because they were viewed as having poor treatment outcomes and poor motivation (Yalisove, 1997). Hence it was unsurprising that alcoholics and addicts felt discouraged from seeking treatment in mental-health facilities and acquired a generally negative view of them.

AA, which was founded in 1935 and rapidly became the substitute for treatments of addictions that were no longer available in hospital and clinic settings. As A.A. grew the National Council on Alcoholism further encouraged this movement and popularised its philosophy. Gradually recovering alcoholics were hired by treatment facilities as lay therapists to the extent that today they occupy the bulk of treatment personal in alcoholism.

For the purposes of this study the term, “SHG” refers to, “on-professional, peer-operated organizations devoted to helping individuals who have addiction-related problems” (Humphreys et al, 2004.p.151). 12-step programs share a group format, however unlike in-patient treatments, 12 step groups discourage program participants from responding to one another’s thoughts and feelings regarding a specific matter, unlike the characteristically confrontational approach evidenced in in-patient substance-related treatments. The rationale underlying this ‘zero-feedback’ approach is to encourage an atmosphere of support that is strictly non-judgemental. Guidelines are provided on what should be spoken about in meetings but above all the wellbeing of the group as a whole must come before the personal needs of one individual. Therefore, individuals attending these SHGs learn over time to speak about problems and challenges that they are faced with in a way that is consistent with fundamental aspects of 12-step philosophy. There are 5 cornerstones of the 12 step program (Greenfield & Tonigan, 2013). They include the following:

1) Stepwork

Stepwork constitutes the basis of the 12-step self-help groups that are available for substance-related disorders. There are, as the name indicates, 12 steps that are done on an ongoing basis. The 12-steps are cyclical in nature, with each successful completion of the 12-steps leading to a deeper process of self-examination. It is this process of self-examination that forms a pre-requisite for continued sobriety and healing. In AA, there is far less written emphasis than there is in NA. Thus, step-work is often verbalised in AA with the exception of certain steps. In contrast, NA advocates prescribe the use of step-work guides which contain detailed questions pertaining to each of the 12 steps. However, in both AA and NA all reflection on the meaning of the steps is subsequently communicated verbally to a sponsor. A sponsor is an individual who has achieved remission for an extended period of time and is believed to have experience where the stepwork process is concerned and also in other areas such as work and health. The difference in written emphasis can be related to the conditions under which AA developed. Briefly, in the absence of large numbers of members with extended members with long term sobriety, it became essential to pass new members of this fellowship as quickly through the steps as possible; thus many of the original A.A. can be understood in terms of an intellectual and rationale concept such as is presented in Step 1 of Alcoholics Anonymous which states,*’ We admitted that we were powerless over our*

alcoholism, that our lives had become unmanageable" (Peyrot, 1985). This, in the context of AA, can be accompanied by a certain amount of written work in terms of thinking about the alcoholic problem but it is generally accompanied a set of actions of a variable nature. Regardless of an individual's preference for either AA or NA, the original intention of the 12-steps was to facilitate a relationship with a Higher-Power (Timko, Debenedetti & Billow, 2006).

2) Higher Power

Defining the concept of a Higher Power would require a separate study but there are several important related ideas that will make findings that are related in the findings and discussion section easier to interpret. The concept of a Higher Power is another fundamental tenet of the 12-step programs and is perhaps the most difficult concept within the 12-step program to define within reasonable parameters. However, a relationship with a higher Power is often equated in these fellowships with the notion of a 'daily spiritual reprieve'. It is a concept that will be taken up in greater depth throughout the following chapters. However, it is important to understand that perhaps above any psychological tools that are used in these fellowships the notion of Higher Power embodies the spiritual permutations of these programmes. In fact, in relation to this concept, all other concerns are considered secondary and peripheral. Importantly, individuals attending these fellowships are encouraged to choose their own conception of a Higher Power. At no point is an individual required to believe in a conception of another person or another doctrine (Vaillant, 2014).

3) Meetings

Both AA and NA 12-step meetings in Johannesburg take place 7 days a week and very often more than once a day in Johannesburg. Meetings serve several important functions. Firstly, meetings act as a support network. Because addiction is often viewed as an anti-social practice, many people attend meetings because of the social support that they obtain from attendance at these meetings that would otherwise be unavailable. Meetings also act as a platform from which important information can be disseminated between members. Information primarily revolves around the 'how to's' of how to stay abstinent and what to expect on this complex journey. Meetings give members a safe environment to share how

they are feeling and what they are dealing with. Meetings also give members the opportunity to speak to more experienced members of these fellowships (Gossop, Stewart & Marsden, 2007). If a member so chooses, it later becomes a prerequisite for a member to ask another member for guidance on working the steps in the form of sponsorship.

4) Sponsorship

Sponsorship is the act by which another member, who is considered to possess an attractive recovery by a younger member (an individual who has very recently become abstinent) ask this more senior member to guide him or her through the step process. Sponsorship embodies the 12-step spiritual principle of, 'we keep what we have by giving it away' (Pagano, Friend, Tonigan & Stout, 2004). The emphasis that is placed on one addict helping another is representative of the deeply embedded belief that the ability to maintain sobriety and/or recovery is contingent on a daily spiritual reprieve that offers an alternative to active substance use and a life of addiction (Young, 2012).

5) Service

The final tenet of recovery worth discussing is the act of service. In line with the spiritual framework of the 12-step framework, newcomers to this program soon learn that their sobriety is contingent on selfless acts including service which includes a wide range of activities including setting up a meeting before the meeting starts, preparing tea and coffee for members, making announcements related to events and activities and most importantly 'carrying the message to the newcomer'. This again reiterates the cyclical nature of this program. Giving important information to a newcomer is a practice that is determined by a member having gained enough experience and information in these fellowships to impart this knowledge to an individual who is new and inexperienced in the practices involved in these fellowships. It is important for the member wishing to impart this information, to understand what is necessary to remain sober/clean or abstinent. Once they believe that they have achieved this they can then begin the process or act of providing support to newcomers to the fellowship as a means of maintaining their own processes of recovery (Pagano al,2004).

The self-help principles of AA and NA have been transformed into professional, non-psychiatric treatments that have become known as the disease concept (Yalisove, 1997). 12-

step programmes utilise the disease concept of addiction and view the abuse of a substance as symptomatic of an underlying disease process which embodies a cluster of symptoms (Alcoholics Anonymous, 2001; Johnson, 1993; Narcotics Anonymous, 2001). This idea is congruent with many popular conceptions of addiction that share a common disease status and are understood as a syndrome or a cluster of symptoms. This type of conception suggests that the interacting bio-psychosocial antecedents, manifestations and consequences of addiction reflect a common underlying addiction syndrome (Grant, 2010; Shaffer et al, 2004).

Thus according to this model an addict's drug/s of choice and maladaptive behaviour patterns are essentially the expression of one and the same thing. Similarly, antisocial behaviours such as poor social conformity, deceitfulness, impulsivity, criminality and lack of remorse among many others are viewed as expressions of the same underlying illness (Shaffer et al, 2004).

Pattison, Sobell and Sobell (1977) describe the disease model of addiction according to the following points.

1) There is a unitary phenomenon that can be described as alcoholism.

2) Alcoholics and pre-alcoholics are essentially different from non-alcoholics. Alcoholics in this instance refers to those who are already addicted to or dependant on the substance, whereas the term pre-alcoholics refers to those individuals who demonstrate the necessary pre-dispositions for becoming addicted to alcohol. These factors can differ from individual to individual. Finally, and for the purposes of this study, the term non-alcoholic refers to those individuals who do not demonstrate a capacity to become addicted as demonstrated by their personal histories and will not become addicted in the future.

3) Alcoholics may sometimes experience a seemingly irresistible physical craving for alcohol, or a strong psychological compulsion to drink.

4) Alcoholics gradually develop a process called "loss of control" over drinking, and possibly even an inability to stop drinking.

5) Alcoholism is a permanent and irreversible condition.

6) Alcoholism is a progressive disease that follows an inexorable development through a distinct series of phases (Pattison, Sobell and Sobell, p.1-2)

SHGs based on the 12-step philosophy of AA are frequently recommended for the treatment of substance use disorders (Weiss et al, 2007). Although there have been conflicting results regarding the role that 12-step self-help SHGs play in relation to CODs, it is now consensus that these groups positively influence substance use outcomes (Timko & DeBenedetti, 2007). Active participation in these groups has consistently been linked to positive drug use outcomes at 6, 12, and 18 month follow-ups (Bogenshutz, Cynthia, Geppert & Goerge, 2006; Weiss et al, 2005). Active participation refers to a variety of activities including making tea and coffee at meetings, reading NA and AA literature and sponsoring among many other activities (Narcotics Anonymous, 2001). In the previous section it was mentioned that individuals attending these SHGs learn from the beginning certain fundamental concepts that embody key concepts embedded with this framework. For example, individual's attending these SHGs commonly refer to being in a process of 'recovery'. This is considered normal and as was demonstrated in the findings section, participants spoke about the phenomenon of recovery without considering whether the researcher actually understood the notion of, "recovery". A similar narrative related to the way in which participants spoke about their substance use in terms of the existence of a disease. These are just two of many examples that will be discussed at different points in this study.

The 12-step program acknowledges that other disorders may impact negatively on the life of an individual but provides no specific details for how to deal with other types of mental disorders. Beyond this acknowledgement, it can only be inferred from the available literature on 12-step philosophy that the principles of this SHG are assumed to benefit those with more severe CODs such as bi-polar and substance dependence, schizophrenia and substance dependence or borderline personality disorder and substance-dependence in the same way that individuals who have less severe CODs such as panic disorder and substance-dependence or major depressive disorder and substance-dependence can benefit. For example, the basic text for AA titled the Big Book of Alcoholics Anonymous states, "there are those, too, who suffer from grave emotional and mental disorders, but many of them do

recover if they have the capacity to be honest" (Wilson, 1938, p. 58). Beyond this, very few suggestions are available for those with more severe forms of CODs.

More recently SHGs orientated around those who suffer from severe forms of CODs have developed. These groups utilise the principles of the 12-step program and are known as, "double trouble in recovery (DTR) self-help groups".

2.8: Double trouble in Recovery Self-Help Groups:

There are few clinical trials of 12-step treatments for individuals with serious mental illness and alcohol or drug dependence. SHGs orientated around helping people with CODs are commonly referred to as,"dual recovery anonymous". These programs have been designed by and for those people with co-occurring psychiatric disorders that are considered very severe (Matusow et al, 2013). They are understood by many to be a safe environment wherein people can discuss things such as what having a mental disorder is like, medication issues and issues around psychiatric hospitalisation. These programmes are becoming more popular for those with severe forms of CODs and have been supported by extensive research regarding the role that SHGs play in the role of those suffering from severe-mental illness (SMI) (Bogenshutz, Cynthia, Geppert & Goerge, 2006).

Because studies have shown that one of the significant challenges that people with severe-mental illness face is a problem of "fitting in",SHGs that are specifically for people with more than one disorder have advantages over those that are designed for individuals with just one diagnosis. However the assertion that these (DTR) groups are preferable for those suffering from severe CODs is premised on studies performed on exclusively AA and NA which make clear the importance of a social support network, structure and accessibility (Noordsy, Schwab, Fox and Drake, 1996).

2.9: Integrated Treatment

Despite the value and importance of models that have been helpful in the treatment of CODs, research has indicated some limitations in the extent to which individuals with very severe forms of CODs can benefit from 12-step interventions (Minkoff, 2001). These issues extend beyond the diagnosis of specific disorders and also pertains to such issues as race and gender. For example, research has indicated that women with CODs often have a history of interpersonal violence and trauma. Research into this specific area has revealed

that interventions that are used for other populations of people with CODs are in fact inappropriate for women with severe CODs (Morrissey, Jackson, Ellis, Amaro, Brown & Najavits, 2005). Similarly, according to Sterling and Weisner (2005) people attending treatment for substance-related problems typically require services beyond what is available and the gulf between substance-related treatment services and psychiatric services is complex (Fabricus et al, 2008; Green et al, 2008).

The history of treatments best suited for people suffering from CODs is quite brief. During the 1980's, when the problem of CODs was identified, traditional substance-abuse treatments, such as group interventions based on the 12-step model, were added to mental health programmes to little avail. Later, interventions in the 1990's began to incorporate such components as assertive outreach, motivational interventions and cultural competence in the context of multidisciplinary teams. These programmes began to show improved results (Peters, LeVasseur & Chandler, 2004). More recently, from 1994-2003, out-patient treatments, brief motivational interventions and long-term treatments have been assessed in an in-depth manner, providing insight into the factors useful for treating vulnerable populations (Drake, O'Neal & Wallach, 2008).

There are multiple approaches to treating CODs. For example, partial treatment involves treating only the primary disorder, sequential treatment involves treating the primary disorder first, and then treating the secondary disorder after the primary disorder has been stabilised while parallel treatment involves the client receiving mental health services from one provider, and addiction services from another.
Finally, integrated treatment involves a seamless blending of interventions into a single coherent treatment package, with a consistent philosophy and approach among care providers. In this approach, both disorders are considered primary. Integrated treatment can improve accessibility, service individualization, real participation in treatment, compliance, mental health symptoms, and the overall outcome (Drake et al, 2008).

2.10: The Four Quadrant Model

Although there is now consensus that people seeking treatment for substance-use disorders frequently present with co-occurring psychiatric disorders, several research initiatives indicating the high prevalence of CODs have highlighted that training in this area should be one of the top training interest areas. However this particular area has been rated as among the lowest in perceived clinical adequacy (McGovern et al, 2006).

In an attempt to address this problem, the four quadrant model which was developed by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), has been proposed as a conceptual framework that characterises the CODs groups by the severity of mental health/substance-abuse disorder and locus of care. The Four Quadrant Model indicates not only the presence of pathology, but also the severity of the problem and its associated symptoms (Flynn & Brown, 2008; Pincus, Burnam, Magnabosco, Dembosky & Greenberg, 2005; Singer et al, 1999).

Each of these disorders may be placed on a continuum, ranging from less serious disorders to very serious disorders. In the case of substance-use disorders, the extreme end of the continuum is chemical dependency, and for mental disorders the extreme end of the continuum is major mental illness. At the other end of the continuum and for substance-related disorders, the problem is classified as substance misuse whereas mental disorders are classified as less serious illness (Singer et al, 1999). These four combinations form a classification scheme that includes:

(1) major mental illness co-existing with chemical dependency ;

(2) Less severe mental illness co-existing with chemical dependency ;

(3) major mental illness co-existing with substance misuse; and

(4) Less severe mental illness co-existing with substance misuse.

The central distinguishing factor between these groups is that people in quadrant 3 are not substance dependent. It is possible that the populations of people that are most likely to

receive a diagnosis of COD are those people in quadrant 1, which, according to this model, are groups of people suffering from severe-mental illness.

Owing to the severity of their disorders it is also likely that these populations would not be able to benefit from 12-step intervention methods alone because the symptoms of their disorders directly interfere with 12-step treatment protocols such as attending lectures, confrontational group therapy and performing various labour intensive tasks while highly medicated**.** Based on the fact that up until very recently there has never been any systematic review of the instruments used in the clinical measurement of addiction, it is possible that behaviours that directly interfere with the 12-step treatment process are inadvertently regarded as a factor that suggests another underlying disorder (Cloutier, Lesage, Landry, Kairouz & Menard, 2012).

Conversely, people who fall within quadrant two of the four quadrants are regarded as suffering from less severe mental illness. According to Singer et al. (1999) these people also appear to suffer from substance-induced symptoms as they abuse substances over long periods of time. These symptoms generally disappear over time.

Because it remains indeterminable the exact length that substance-induced symptoms and/or disorders will persist for and based on the fact that substance-related treatments are time limited, it is possible that many people who would otherwise be diagnosed as having CODs do not in fact receive this diagnosis because (1) these symptoms may be attributed only to active drug-use and/or (2) because these individuals do not remain in treatment long enough to receive an accurate diagnosis.

Of particular interest to this research are individuals who are located in quadrant 1 and quadrant, 3 as these quadrants represent populations that have both serious co-occurring mental illness and suffer from chemical dependency. However, all those individuals who suffer from CODs are of interest to the study to the extent that all of these individuals do, by definition, suffer from at least one kind of substance-related disorder.

2.10.1: Quadrant 1-Major Mental Illness and Chemical Dependency

According to Singer et al. (1999), the first quadrant of this model represents a population of people that are at particular risk for relapse. Individuals in this quadrant have a primary

mental illness Axis 1 diagnosis of chronic schizophrenia or major mood disorder including bi-polar disorder and/or major depressive disorder (MDD), and/or Axis II diagnosis of severe personality disorder including antisocial personality disorder (ASPD) or borderline personality disorder (BPD) combined with chemical dependency involving alcohol and other drugs. These disorders denote a population of individuals that would be described as having a severe mental illness (SMI) (Drake, Mueser, Brunette & McHugo, 2004). Clients in this quadrant tend to be male, under 40 years of age, single and of a lower socioeconomic status (SES) although they may have previously come from a higher SES. High rates of addictive comorbidity are present in young adult chronic patients (Singer et al, 1999).

2.10.2: Quadrant 2-Less Severe Mental Illness Co-existing with Chemical Dependency

People within this quadrant suffer from milder mental illness; such disorders are post-traumatic stress disorder (PTSD), anxiety disorders, less severe mood disorders, eating disorders, attention-deficit disorders and, in adolescents, oppositional defiance disorders (Singer et al, 1999). As those in this quadrant usually have a long history of substance abuse, it is common to observe substance-induced psychiatric symptoms. These symptoms are not psychotic in nature however, and generally diminish following the cessation of substance use (Singer et al, 1999).

2.10.3: Quadrant 3-Major Mental Illness and Substance-abuse

Clients in this category have a primary Axis 1 diagnosis of major mental illness, generally of the schizophrenic or affective type, including MDD and bipolar disorder and/or and Axis II diagnosis of severe personality disorder including ASPD or BPD with infrequent use of non-prescribed chemical substances. This population is also considered vulnerable. The duration of their mental disorder ranges from very recent onset to extensive or chronic, with an age range which spans the entire period from late adolescence to very advanced age. With the exception of age, the socio-demographics of this population are quite similar to those of quadrant 1; however, some characteristics may be less extreme than in the first quadrant. For example, persons in this quadrant may remain employable even if only a small percentage (15%) is employable (Singer et al, 1999).

The central distinguishing factor between these groups is that people in quadrant 3 are not substance dependent. However, Singer et al. (1999) propose that both populations should

have abstinence from alcohol and other non-prescribed substances as a primary goal because of the severe nature of their disorders.

2.11: Theoretical Views on CODs:

Various authors have understood the CODs phenomenon differently. Certain aspects of different theories have already been discussed. According to Fabricus et al. (2008), there are five main theories that have been used by researchers in the field of addiction to better understand people suffering from these disorders.

1. The no-causal relationship hypothesis. This theory suggests that the substance-related disorder did not cause the psychiatric disorder/s and that the psychiatric disorder/s did not cause the substance-related disorder. Therefore the two different kinds of disorders exist but they are mutually exclusive.
2. CODs exacerbate the symptoms of psychiatric and substance-related disorders. This theory suggests that a pre-existing COD makes the substance-related problem and other psychiatric problems more severe.
3. The CODs developed from a common vulnerability for both disorders hypothesis.
4. The self-medication/the psychiatric disorder is premorbid. This theory will be expanded in this section. It is used throughout this study as a framework to help understand both psychiatric illnesses and substance-related disorders.
5. The substance-related disorder is premorbid. This theory has already been discussed in great detail. It is important because it exerts a significant influence on the worldviews of the participants that participated in this study.

For the purposes of this study, the self-medication hypothesis (SMH) is utilized as the primary framework for conceptualizing co-occurring disorders. Theorists have placed considerable efforts in attempting to identify the psychological vulnerabilities, disturbances and pain that predispose individuals to become chemically dependent (Mariani, Khantzian & Levin, 2014). The overall findings from these studies suggest that continued and severe substance use is associated with severe psychopathology. The psychology of such behavior is typically within the specific context of using recreational drugs, psychoactive drugs,

alcohol, and other forms of behavior to alleviate symptoms of mental distress, stress and anxiety, including mental illnesses and/or psychological trauma, is particularly unique and can serve as a serious detriment to physical and mental health if motivated by addictive mechanisms (Mariani et al,2014). This way of understanding substance-related problems is consistent with the self-medication hypothesis and/or the psychiatric disorder is premorbid hypothesis.

As different drugs have different effects, it is possible that they are used for different reasons. According to the SMH, the individuals' choice of a particular drug is not accidental or coincidental, but is instead, a result of the individuals' psychological condition, as the drug of choice provides relief to the user that is specific to his or her condition (Khantzian,1985). Specifically, addiction is hypothesised to function as a compensatory means to modulate painful affects and treat distressful psychological states, whereby individuals choose the drug that will most appropriately manage their specific type of psychiatric distress and help them achieve emotional stability.

According to Khantzian (1985), drug dependent individuals generally experience more psychiatric distress than non-drug dependent individuals, and the development of drug dependence involves the gradual incorporation of the drug effects and the need to sustain these effects into the defensive structure-building activity of the ego itself. The addict's choice of drug is thus a result of the interaction between the psychopharmacologic properties of the drug and the affective states from which the addict is seeking relief. The drug's effects substitute for defective or non-existent ego mechanisms of defense. The addict's drug of choice, therefore, is not random.

Khantzian (1985), on revisiting the SMH, found evidence suggesting that psychiatric symptoms, rather than personality styles, lie at the heart of drug use disorders. Khantzian (1985) specified that the two crucial aspects of the SMH were that (1) drugs of abuse produce a relief from psychological suffering and (2) the individual's preference for a particular drug is based on its psychopharmacological properties. The individual's drug of choice is determined through experimentation, whereby the interaction of the main effects of the drug, the individual's inner psychological turmoil, and underlying personality traits identify the drug that produces the desired effects.

Conversely, less excessive substance use is associated with less severe pathology (McLellan, 1986). At the treatment level, substance-abuse has traditionally been regarded as a medical problem and rehabilitation programmes most often use treatment strategies based on the disease model that locates pathology in the body (Fabricus et al, 2008). Although this model for treating substance-related disorders is a sound framework in its own right, the application of it to every person attending a substance-related treatment centre can be inappropriate especially when certain of these individuals require individual treatments that are tailored to their needs (Engel, 1977). Tailored interventions are necessary for both individuals who are afflicted with severe forms of mental illness and also to those individuals who suffer from less severe forms of mental illness.

It seems enigmatic that insights regarding the prevalence of CODs have been around for a long time; yet it is only recently that CODs have become a treatment focus. As has been discussed, there still exists a significant disjuncture between the psychiatric field and the substance-abuse field, each employing their own models for treating pathology. However, Richards (1993) argues that the current social and health care environment presents us with the opportunity to better recognise these disorders because of the increased need for specialisation and the advances that have been made in psychopharmocology (Forray & Sofuoglu,2012).

These two advancements have had important implications. In the first instance, the increased need for mental health services and competency bases has grown exponentially; allowing for much needed specialisations to occur in fields such as CODs. In the latter case, the advancements that have been made in psychopharmocology have allowed people who would ordinarily require institutionalisation to function as other people do in society (Forray & Sofuoglu, 2012; Richards, 1993).

Richards (1993) found that for individuals presenting for either mental health treatment or substance-abuse treatment centres, observed over a six-month period, the co-morbidity of alcohol disorders and mental illness was 55%;. For drugs other than alcohol the co-morbidity rates were 64.4%. Thus at the time that Richards was recording these findings, more than half of the individuals presenting for substance-related treatments suffered from one or more CODs. With more research into the CODs phenomenon since then, prevalence rates of as high as 90% have been ascertained through research (Fabricus et al, 2008; Ibanez

et al, 2001; Kineast, Stoffers, Bermpohl & Lieb, 2014). More recent findings on CODs also suggest that it is unusual for an individual to be diagnosed with substance-dependence and not to be diagnosed with another psychiatric disorder (Jacobson, Southwick & Kosten, 2001).

Why then is there still debate regarding the prevalence of these disorders? One plausible explanation for this is that although there has been much research exploring the prevalence of CODs in treatment populations, there is still an absence of the necessary conceptual frameworks to diagnose these disorders. It is therefore essential for both practitioners working in the field of substance-related disorders and researchers to produce more information on these disorders so that future treatment interventions can be of greater assistance for individuals with CODs.

2.12: Concluding Thoughts

In light of what has been presented so far, it is clear why it is important to understand how people with CODs manage to reach a state of full recovery. Presently, people suffering from these disorders are receiving the incorrect diagnosis or inadequate diagnoses where for example, they receive a diagnosis of substance-related disorder but do not receive a diagnosis of any other disorder. Further compounding the issue is that the availability of the screening tools that are required to makes a formal diagnosis of CODs are not yet sufficiently developed. It is likely that more research into developing conceptual tools for this phenomena and greater exploration of the processes to recovery for those suffering from CODs could be greatly helpful in offering these people better forms of treatment in the future.

This literature review makes clear several pertinent ideas. First, there are certain CODs populations that are particularly vulnerable to negative conditions in living. These people appear to be in need of a modified and/or integrated treatment approach that is able to help these people deal with multiple problems.

Second, epistemological differences between the mental health and addiction fields, specifically with regard to how CODs and substance-related problems are conceptualised in these different treatment settings, pose a major barrier to implementing potentially valuable treatments to those suffering from CODs. This is just one example of how systemic

differences in approaches to COD's can pose major problems. Thus a broader framework that goes beyond traditional 12-Step orientated methods is required to attend to the needs of certain populations.

Finally, because 12-Step frameworks are the most widely used frameworks in the treatment of substance related-disorders it is proposed that modification to these programmes rather than a completely separate treatment regime is necessary to begin to address some of the issues related to the CODs phenomenon. If these research propositions are viable then it could mean that 12-step orientated programmes would need to be appropriately supplemented to include treatment programmes that cater for the additional diagnosis of COD's where appropriate.

2.13: Research Questions

1) Are there any common elements in the experiences of those who have recovered from CODs and substance-related disorders?
2) What therapeutic aids have been helpful to the participants?
3) Are there any factors that have had a detrimental effect/or acted as a barrier to the participants processes of recovery?

Chapter 3: Methodology

3.1: Introduction

"From what rests on the surface one is led into the depths" (Husserl, 1936, as cited in Welton, 1999, p.4).

This chapter describes the procedure of the study. The procedure includes a discussion of the methods that were used to carry out the study and its underlying philosophical roots. The relevance of qualitative research in psychology and the appropriateness of the various methods employed in analysing the data that was collected. The characteristics of the sample and some related factors are also taken into account to help illustrate why the chosen sample was appropriate for this study. The construction of the interview process is outlined along with how the potential participants were recruited and finally, the relevant ethical concerns are discussed as well as how ethical approval for the study was attained**.** These factors helped demonstrate why the approach/s used in the study were valuable and appropriate to the questions that the study sought to explore.

This research was qualitative in nature. It aimed to explore the experiences of a group of people who had managed to recover from CODs and substance-related disorders. In order to effectively describe the process of recovery from a CODs and substance-related disorders it was necessary to include and discuss their personal insights into what they had found helpful in terms of therapeutic aids/health related measures as well as some of the factors that they had found detrimental to their personal processes of recovery. The primary strategy was orientated around making sense of the different experiences of a group of individuals who had, as a result of their disorders, been subjected to a series of life experiences that were relevant to the questions being asked in this study. This study was not aimed at predicting human behaviour. Importantly, in order to effectively interpret the collected experiences of these individuals, it was necessary to utilise a broad range of theoretical concepts. While not in and of themselves constituting the overarching theoretical framework, the researcher felt the use of various psychodynamic, spiritual and

community oriented concepts was critical in engaging the scope of data collected and the phenomena that this data represents.

Thus a qualitative research design was utilised because the primary aim of this study was to gain insight into how the participants constructed their processes of recovery rather than to ascertain the prevalence of these disorders or to describe the way that the participants may fair in the future based on the type of disorder that they had. Broadly, analysing what the participants prioritised in terms of factors that they viewed as beneficial as well as those factors that they perceived as detrimental to their processes of recovery.

3.2: Relevance of qualitative research in psychology

Qualitative research is a method of enquiry employed in many different academic disciplines, traditionally in the social sciences. Qualitative researchers aim to gather an in-depth understanding of human behaviour and the reasons that govern such behaviour. The qualitative method thus aims to explore the why and how of human behaviour rather than simply the what, when and where. Thus smaller and more focused samples are generally used as opposed to larger samples. However since as early as the 19th century research psychologists have supported the notion of objective measurement and identification of psychological variables with statistical associations as a primary research method (Murray & Chamberlain, 1999, as cited in Griffiths, 2009).

In the early 1900's, some researchers rejected positivism, the theoretical idea that there is an objective world which we can gather data from and verify this data through empiricism. These researchers embraced a qualitative research paradigm, attempting to make qualitative research as rigorous as quantitative research and creating myriad methods for qualitative research. In the 1970's and 1980's the increasing ubiquity of computers aided in qualitative analyses, several journals with a qualitative focus emerged, and post positivism gained recognition. Throughout the 1990's the concept of a passive observer/researcher was rejected, and qualitative research became more participatory and activist-oriented. Researchers also began to use mixed methods approaches, indicating a shift in thinking of qualitative and quantitative methods as intrinsically incompatible (Griffiths, 2009).

Edmund Gustav Albrecht Husserl was a German philosopher who established the school of phenomenology (Welton, 1999). He broke away from the positivist/scientific orientation of the science and philosophy of his day. He believed that experience is the source of all knowledge and developed a method of phenomenological reduction by which a subject may come to know directly an essence.

Defining phenomenology is a very difficult task. In some ways it can be argued there are as many ways of defining phenomenology as there are phenomenologist's (King, 2014). One of the central features of the debate concerning how phenomenology should be defined rest in concerns as to whether phenomenology is an approach or a method. This has made it difficult to provide a template for a definitive research process. As a result the phenomenological approach has often been viewed with skepticism and a resulting debate concerning the rigor and trustworthiness of the approach (King, 2014).

As one of its primary aims is to describe human experiences this research can be placed within the broad category of descriptive psychology (Giorgi, 2003). In phenomenological research the terms "methodology" and "method" are viewed separately. The former refers to the philosophical framework that must be assimilated so that that the researcher is clear about the assumptions of the particular approach he or she has selected, whereas the latter refers to the procedure used to carry out the research (Caelli, 2001).

In the case of this research the methodology will be based on the philosophy of phenomenology, while the method or research technique will be in depth-semi-structured interviews. In this research the un-interpreted experience of suffering from CODs and substance-related disorders and managing to achieve a state of full recovery will constitute the basic experience that will later be used in the creation of data.

The primary purpose of utilising a phenomenological approach was to describe the various sets of lived experiences of people who have recovered from CODs and substance-related disorders and therefore the research design chosen for this study was strongly linked to its purpose (Malterud, 2001). These descriptions will then be used as the results (Stangor, 2010).

Phenomenology is the study of subjective experience. It is an approach to psychological subject matter that has its roots in the philosophical work of Edmund Husserl. Early phenomenologists such as Husserl, Jean-Paul Sartre, and Maurice Merleau-Ponty conducted philosophical investigations of consciousness in the early 20th century. Their critiques of psychologism and positivism later influenced at least two main fields of contemporary psychology: the phenomenological psychological approach of the Duquesne School (The Descriptive Phenomenological Method in Psychology), including Amedeo Giorgi and Frederick Wertz; and the experimental approaches associated with Francisco Varela, Shaun Gallagher, Evan Thompson, and others (embodied mind thesis)(Welton,1999).

Because phenomenology as a school of philosophical thought underpins just about all qualitative research, there are some researchers that argue that all qualitative research is phenomenological in nature (Giorgi, 2003). However, in the same way that ethnography for example, focuses on the study of culture, so does phenomenology focus on the essence or structure of an experience. A point blank definition of phenomenology would be orientated around both the study and description of phenomena. As such phenomenologists believe in the importance of subjectivity.

3.3: Alcoholics Anonymous and Narcotics Anonymous as the Research Site

It was important to choose the correct site/s at which to conduct this study. The popular SHGs of NA and AA were chosen because they were believed to possess individuals that had experienced what it was like to suffer from CODs as all of them were previously substance-dependant. These individuals also understood what was required to recover from a COD and/or a substance-related disorder. AA was the first of the many 12-step fellowships that now exist with extensive support groups based on the AA framework existing for nearly every nameable addiction (Gabhainn, 2003).

In the early years of AA there was the commonly held belief that people attending these self-help groups were ‘end of the line drunks’. The generally held conception was that it was a place for people who were there as a result of near death experiences related to alcohol consumption or because these individuals had become a danger to society and themselves. This conception was consistent with the first and second editions of the diagnostic and statistical manuals, wherein alcoholism and drug addiction were classified under the

category of personality disorder and regarded as types of sociopathic disturbances. As has been discussed, conceptualising addiction as a personality disorder and/or disturbance was changed with the publication of the DSM III which separated substance-use disorders from personality disorders (Ball, 2005).

However, in recent years 12-step fellowships have received a great influx of younger people who do not necessarily fit the profile of alcoholic and addict put forward by AA and NA doctrine. Thus the appearance and use of 12-step fellowships such as AA and NA has represented a confounding of traditional conceptions of what it means to be addicted to substances (Kelly, Myers & Brown, 2000). Specifically, issues such as poly-substance abuse often serve to confound generic treatment approaches because individuals presenting with poly-substance abuse do not conform to a drug of choice as such. Furthermore, with the increased potency of the substances that are now available; often the severity of substance-related issues is also increased (Ludici, Casternuovo & Faccio, 2015).

In light of the improvements in efficacy of various research methods and treatment approaches; there has been a growing awareness in these fellowships around the need to address other underlying issues and disorders that may exacerbate the addiction related problem or even be causing it in the first place.

As the 12-step paradigm for treating substance-related disorders has demonstrated remarkable results in terms of substance use cessation and improvement in overall quality of life; the need to understand the way that individuals attending these SHGs are able to derive benefits has become a regular research topic of exploration and importance. Furthermore these fellowships have needed to themselves adapt as result of individuals with more severe forms of mental illness attending them. Thus 12-step fellowships are engaged with a new set of problems that are related to new trends in substance use emerging including different patterns of drug use such as poly-substance abuse as well as the development of new synthetic substances that are often highly addictive and harmful.

Thus the conception of DTR self-help frameworks was announced a means to provide emotional support to those individuals afflicted with more severe forms of psychopathology. While these self-help groups have helped to provide essential forms of care and support to individuals suffering from wide ranging CODs there is also a growing

body of research that suggests that certain individuals, particularly those with more severe forms of co-occurring psychopathology, are not able to derive the same kinds of benefits from these fellowships that individuals with less severe forms of mental illness are. However in light of the lack of integrated treatments for these kinds of disorders that currently exist in South Africa; people who would not ordinarily benefit from this kind of intervention and support group continue to seek help there because of issues in accessibility of psychological services and a lack of information regarding what CODs are and the danger that they pose to the life of the individual.

3.4: Procedure: Gaining access to the sample

This research project took place at neutral venues in Johannesburg at a time of the participants choosing. It was necessary to choose a neutral venue because all of the participants chosen for the study shared certain similar experiences. So as to avoid an over-identification with the frameworks that are used in these SHGs, a neutral venue was chosen for the study. The researcher felt that a neutral venue would encourage more reflection than meeting with the participants at the 12-step meeting sites themselves.

Permission to deliver a special notice explaining the importance of treating psychiatric disorders to people attending 12-step meetings was requested via the Johannesburg AA and NA service websites. This notice was for obtaining permission to conduct the study (jhb-pr-chair@na.org.za). Discussions with the available service representatives gave the researcher a better understanding of how these SHGs function. These service representatives were considered to be gatekeepers in this study as permission to conduct the study was contingent on whether they viewed the study as relevant and valuable. The matter to be considered was whether it was of value to the people that actually attended these SHGs. After it was confirmed that the study was in fact to produce knowledge on the factors that help in the recovery process, access to these fellowships was granted.

The service representatives were able to make valuable suggestions as to the various meetings to be approached. More specifically they were able to indicate what kinds of groups would contain individuals that met the selection criteria for this study. After the researcher decided what meetings were to be used for the study to recruit potential participants, the researcher indicated to the relevant service representatives which

meetings participants should be recruited from. The selection was based both on the suggestions of the service representatives and convenience in terms of areas.

The meetings selected included both AA and NA meetings as both groups contained individuals who had recovered from CODs. These groups also evidenced a group of individuals whose addiction-related pathology included primarily substance-related disorders. Once the request was approved from the higher service committees; the researcher then approached the general service representatives (GSR's) of individual meetings used to recruit participants so that he/she could personally deliver the notice at the end of these meetings. As there were several announcements concerning fellowship development, rehabilitation and attaining psychiatric assistance taking place at these meetings; an announcement concerning participation in a study did not present itself as unusual to anybody attending these meetings.

This verbal notice was accompanied by an information sheet that contained the researcher's contact details. Handing out these details was done so that any participants who were interested in the study could contact the researcher if they felt that they wanted to participate in the study and/or if they required further information about the study. Once participants contacted the researcher and expressed interest in the study; times and dates for the interviews were set up individually.

3.5: Sample

Participants and Recruitment process

In qualitative research a larger sample is often sacrificed in the pursuit of gaining a richer understanding of the phenomenon of interest. Twelve participants were selected to be interviewed for the study. After 12 interviews had been conducted the researcher felt that the data had reached saturation point in that there were enough regularities in the data collected to begin creating themes (Brocki &Wearden, 2006).

In order to capture data that was relevant to and answered the questions, the researcher chose a group of participants that would be able to speak about the areas of interest extensively. These areas were CODs and substance-related disorders. The sample of interest was chosen because they were felt to offer useful manifestations of the phenomenon of

interest. More simply phrased, the participants had relevant experiences with mental illness and substance-related problems.

Participants were identified and recruited from several 12-step meetings. The selection criteria for participating in this study were (1) the participants must have had at least 5 years of continuous abstinence from any psycho-active substance with the exception of prescribed medications and (2) that they must have attended between 6-12 months of individual therapy during this 5-year period. The biographic details of the participants are as follows:

	Age	Race	Educational level	Diagnosed CODs	Length of abstinence	Drug of choice
1)Arthur	57		Matric/entrepreneur	Mood disorders/psychotic symptoms-unspecified	7 years	Poly-substance abuse
2)Brian	45	white	Unspecified	Unspecified	9 years	Alcohol
3)Hanna	56	White	LLB	Bi-polar disorder	6 years	Alcohol
4)Sara	48	White	BA	Bi-polar disorder	13 years	Heroin
5)Martha	52	White	Secretarial training	Mood and anxiety disorder/unspecified	7 years	Opiates/Painkillers
6)Edgar	55	White	Entrepreneur/Entertainment	Unspecified	17 years	Cocaine
7)Garth	42	White	BA	Unspecified	6 years	Cocaine/Alcohol
8)Micheal	46	White	BA	Depression/Panic disorder	9 years	Cocaine/Alcohol
9)Kayla	45	White	Matric	ADHD	11 years	Cocaine
10)Gideon	62	White	Matric	Unspecified	14 years	Cocaine/Crack-cocaine
11)Ryan	32	White	Entrepreneur	Mood disorder/s/unspecified	7 years	Poly-substance abuse
12)Daniel	58	White	Pharmacology	Unspecified	9 years	Crack-cocaine

All of the participants selected for this study were white. This was unfortunate because it set up limitations in terms of what could be inferred about this group of participants at the outset of the study. Although the study was open to any individuals who met the criteria for selection; the first 12 participants willing to participate in the study were selected so as to ensure that time related goals for the study were met. The participant information sheet briefly discussed the nature of the study and informed potential participants of what was required to participate in the study. If potential participants still required further

information the researchers contact details were made available so they could contact him. This research project used one sample consisting of 12 participants.

The researcher had a document containing the names of those who had agreed to participate in the study and the participants were interviewed on an availability basis. Because the sampling framework was aimed at insight about the phenomenon of interest rather than empirical generalisation from a sample to a population, it followed a purposive sampling framework (Patton, 2002).

The interviews began as soon as the Human Research Ethics Committee of the University of the Witwatersrand approved the proposal for the study. Immediate arrangements were made to set up interviews with the potential participants who met the criteria put forward in the participant information sheets. The researcher met them in venues of their own choice within the city of Johannesburg. He recorded the interviews and transcribed the data according to the specifications of the methodology of phenomenology. The interviews took between 45 minutes and 2hours. The interviews were completed by the end of August 2014.

3.6: Data collection method: Semi-structured interviews

A central aim in this study was to capture the participants' perceptions, and the primary strategy of using semi-structured interviews was to poll the unique thoughts, attitudes and beliefs of the participants. This approach was relevant and useful as it allowed participants with varying histories to speak about what it was like for them to suffer from CODs and substance-related disorders (Bargn & While, 1994). This information was then used to develop a greater understanding of CODs and substance related disorders in the context of 12-step recovery groups, as well as to critically evaluate the effectiveness of the various methods that the participants of this study had utilised in order to recover.

Data was acquired from recorded interviews with the participants. Although interpretive phenomenological analysis can include focus groups, participant diaries and self-reports; semi-structured interviews have proven to be an exemplary method of data collection (Smith and Osborn, 2003). This success is because interviews allow subjects to be closest to

their personal lived experiences (Kruger, 1979). Thus, in terms of the interview technique the researcher decided that semi-structured interviews were the best method for collecting these 'experiences'. By semi-structured it is meant that an interview schedule exists but it does not have to be followed in the exact order in which it is written. Semi-structured interviews also allow for flexibility without the risk of leaving something important out (Breakwell, 1995). The difference between semi-structured interviews and more rigid psychological techniques can be located in the degree of flexibility that interviews allow the respondents (Kruger, 1979). Semi-structured interviews were also selected because the history of these participants varied greatly, in this way, precluding the use of a standardised interview schedule.

Semi-structured interviews also allowed the researcher to develop a close rapport and sense of trust with the participants. This may have motivated the participants to continue with the interview and have led to more honest and open responding (Stangor, 2011). Finally, semi-structured interviews allowed the researcher to explore respondents' opinions, clarify interesting and relevant issues, and explore sensitive topics (Bargn & While, 1994).

An interview schedule was prepared ahead of time but was subject to several changes before ethical approval was granted to conduct the study. The researcher wanted to use a set of questions that encouraged the participants to reflect on their life experiences as much as possible so as to ensure that the richest data possible was collected. Producing an interview schedule prior to the actual interview process allowed the researcher to make relevant changes to the interview schedule. Things such as the way that questions were worded were taken into account, as the wording may have affected the responses of the participants, particularly where sensitive areas or topics of discussion were being discussed. These aims were consistent with the phenomenological approach where the emphasis is on attempting to understand the psychological conceptions of the participants (Smith, 1995).

The interview questions asked the participants about their personal experiences of living with addiction and what it had taken for them to reach a state of recovery. The questions allowed them to speak about anything that they felt was relevant. For example the first five questions in the interview gave the participants a chance to reflect on some of the progress

that the participants had made in their lives. The first question in the interview explored some of the basic changes that had taken place in the participant's lives since becoming abstinent. The next four questions gave the participants a chance to expand on things that they felt were relevant to their lives and the study. These questions asked the participants to reflect on some of the general areas that had been helpful to them in their recoveries as well as some of the things that had been challenging to them. There was a specific emphasis on attaining from the participants those factors that were seen as supporting the recovery process and those that were detrimental.

During this interview process the researcher remained flexible. Remaining flexible meant that if the participant being interviewed wanted to discuss something that was unrelated to the questions being asked, they were welcome to continue. Similarly, if a participant wanted to discuss something in an in-depth manner and if it was appropriate; the researcher would comment on or clarify what the participant appeared to be feeling (For example, 'I can see that you are very proud of the immense changes that have taken place in your life; is there anything else that you would like to say on this question?'. For the most part, this resulted in very detailed data being provided.

The primary goal was to get information on what life was like living with CODs and substance-related disorders and substance-related disorders and, furthermore, to learn how the participants had managed to recover. The interview questions themselves did not specifically ask the participants about the COD construct or about substance-related constructs for several reasons. It was assumed at the outset of the study that none of the participants would understand what CODs were. This was because even in professional circles, the concept is still new and there has been dispute regarding how CODs should be defined. Furthermore, even though certain of the participants acknowledged that they had other psychological disorders, they did not recognise these disorders as co-occurring disorders.

The researcher was also very aware that these individuals would show a high level of identification with the fellowships that they attended and a result may not be forthcoming when discussing the nature of other psychiatric ailments. Any potential unwillingness to

discuss matters such as other psychiatric ailments was further complicated by the fact that these groups utilise a strictly zero-feedback policy. Therefore if an individual attending these groups feels the need to discuss a psychiatric ailment, s/he will not receive any advice or suggestions on how to deal with in the interests of maintaining a non-judgemental atmosphere.

As has been previously discussed, individuals who attend these self-help groups utilise the disease model through which they conceptualise their illness. Furthermore, these individuals are taught to apply these models to their lives while sober and therefore it is possible that often other psychiatric ailments are understood in terms of the substance-related disorder or disease. It was also possible that mentioning the CODs construct may provoke anxiety in the participants by introducing different frameworks and thus affect the responses that that they gave and their greater recovery processes. Therefore, questions pertaining directly to CODs were omitted from the interview schedule. This decision was made with both the interest of getting the most detailed responses possible and also to perform the interviews in a manner consistent with the ethical principle of ensuring the protection and welfare of the participants at all times. The researcher was highly respectful of this and thus he did not pursue any line of conversation wherein there existed the potential to cause uncomfortable feelings through introducing alien and conflicting content.

After several interviews it became clear that there were certain patterns of response that emerged in response to the interview questions. This allowed for important areas to be explored in an in-depth manner. For example, asking the participants about how their lives had changed since recovering resulted in all of the participants unwittingly providing a personal definition of recovery. Although this in itself was not a primary aim of the study it was later presented in the discussion and findings section as an important sub-theme that had important implications for the overall findings.

The last four questions each had an individual focus. They asked the participants about their experiences with health care professionals and about what they felt was harmful to their recoveries. Every juncture allowed the participants to describe their personal experiences without the questions forcing the participants to answer in a certain way. All through this

process the participants were encouraged to speak about meaningful events and practices in their lives. This was in keeping with the phenomenological method employed in this study, which allowed for whatever was said during the interviews to be viewed as unique experiences. This allowed for in-depth exploration. Whatever the participants said was regarded as valuable and unique. After each interview the researcher thanked each participant for his/her time, explaining again the aim of the study. To facilitate the generation of reliable data, the researcher reassured each participant that his or her confidentiality would be protected and respected at all times. At the end of the interview the researcher asked the participant whether there was anything more she or he would like to add.

Once a participant expressed interest in participating in the study, an individual interview was arranged with each one of the participants at a location of his or her choice, including the treatment centre or another place. The researcher ensured there would be an adequate degree of privacy, and that participants had put aside sufficient time to give full attention to the interview. As was the case in one of the interviews, the researcher needed to complete a follow up interview as the allotted time was insufficient to answer all of the questions. The researcher also ensured that before each interview he was equipped with a working tape recorder, consent form and information sheets.

3.7: Data analysis

Interpretive phenomenological analysis (IPA)

The researcher approached the data that was collected with two aims in mind. Firstly, the researcher attempted to the best degree possible to understand the world of the participant and to try and describe what it was like. In order to do this effectively, it was necessary for he researcher to employ the works of several prominent authors in the field of addiction and CODs so as to ensure accuracy in the description of the findings**.** The second aim was to lay aside as many presuppositions about the data as was possible and then to lay these interpretations against the broader social, cultural and theoretical context (King, 2014). These goals enabled the experiences of the participants to be understood and relayed accurately in the final write up. Once all the data had been captured, the researcher

transcribed all of it and then rechecked the transcripts to ensure there were no errors. This helped familiarise the researcher with the data, and served to lay a solid foundation for the first stage of the data analysis.

The analysis was guided by interpretive phenomenological analysis (IPA), which is a method that focuses on an individual's lived experience (Shaw, 2001). IPA is the most recent of all the approaches to qualitative enquiry (Clarke, 2010). It can be viewed as an alternative to discursive approaches. Discursive approaches aim to provide an alternative to mainstream psychology and are strictly anti cognitivist. For example, discursive approaches seek to deconstruct core cognitive constructs such as attitudes and body image. IPA aims to "dialogue with mainstream psychology" (Clarke, 2010, p.3). Thus one of the central aims of IPA is to identify and describe phenomena as they are experienced by the participants. By this it is meant that IPA specifically focuses on peoples lived experiences and the meanings they attach to these experiences. The aim of interpretive phenomenological analysis is to allow for a rigorous or in-depth exploration of subjective experiences and social cognitions (BIiggerstaff & Thompson, 2008). The steps that were followed after the interviews are taken from Giorgi. (2003).

1. The researcher read the entire set of transcripts in order to get a general sense of what had been said. This involved reading the transcripts many times to get a good overall sense of what had been said and to make future reference easier. This process involved becoming more familiar with initial codes and future themes. While reading the transcripts the researcher kept notes for ideas that he felt had relevance to the study.

2. Once a sense of the data had been developed the researcher then went back to the beginning and read through each text once more with the specific aim of discriminating 'meaning units' from within a psychological perspective and with a focus of the phenomenon that was being researched. Meaning units in this instance refers to clusters of information that resemble one another and refer specifically to one concept. The researcher continued to make notes as he read and re-read the transcripts.

3. Once meaning units had been delineated, the researcher then went through all of the meaning units that were most revelatory of the phenomena under investigation. This was the stage where initial codes were developed and were recorded on a separate transcript. It was constantly updated until the researcher felt that he had sufficiently explored and analysed what the participants had said. At this point the researcher developed what King. (2014) refers to as," first order constructs" (p.174). In this study a construct was understood as either an abstract or specific idea relating to the phenomenon under investigation. These constructs were accompanied by verbatim quotes from the actual transcripts provided they were deemed appropriate to construe a particular idea. Thus units of meaning were extracted from the actual transcripts. The researcher then did away with what he felt was irrelevant to the study or those meaning units that later became redundant. Special emphasis was placed on how a participant understood a particular phenomenon

4. Finally the researcher synthesised and transformed meaning units into a consistent statement regarding the subject's experience, which was expressed at a number of levels. This stage was viewed in terms of the creation of second-order constructs and derived themes. (King, 2014). The difference between the previous stage and this stage was that in this step the researcher himself interpreted the data from his own perspective. Through the appropriate grouping of second-order constructs the researcher began the process of deriving themes. Special attention was given to this stage as this is where the researcher began to forge connections between the different themes. Forging connections created meaningful relationships between the themes used in the final write up.

5. Producing the report was the final stage. The researcher had a set of fully worked-out themes and was able to perform the final analysis and write up of the report. The goal was to tell the story of the results in a way that would convince future readers of the merit and validity of the analysis. Of equal importance was presenting the results in a concise, coherent and logical way while retaining

sufficient data to demonstrate the prevalence of each theme. Furthermore the findings were treated with the utmost respect and sensitivity. The assumptions of IPA were clearly explicated. There was a match between the researcher's aim and what had actually been done. The language and concepts used in the report were consistent with the epistemological position of the analysis. Therefore the researcher's position in the analysis had been active. Sufficient time was allotted to complete all of the phases of the analysis adequately. Finally, it is important to express that while the guidelines are important in using IPA as an approach; such guidelines are intended for adaptation (Brocki & Wearden, 2006).

3.8: Difficulties Associated with Phenomenology as a Research Method

The difficulties associated with phenomenology as a research method are discussed below because if they are not circumvented, they could become a limitation of the research. In other words the difficulties associated with the method are potential limitations**.**

Caelli (2001, pp.274-275) offered useful guidelines to persons who intended engaging in the challenge of phenomenological research. Her experience is cited quite extensively in phenomenological literature. Failure to heed her advice could undermine the quality of the research.

She maintained that what was said, and what was meant, were not the same thing. This resonates with the experience of the interview process in general that reflects some of the domains of what can be understood as language games. Caelli. (2001) therefore imbued the science of interpretation and the skills of its implementation with much importance. Caelli (2001, p.274) further acknowledged that:

> *It was only after many episodes of trying to discover the sense of the words, hesitations, or incoherencies in the data and seeking to clarify the sense made of particular passages with the participant that I recognized that this was interpretation in action.*

It is quite evident that this thesis will involve a similar process of trying to discover the sense and meaning of the participant's recovery experiences. Caelli (2001, p.274) explained that, "later, after intense reflection, writing, and rewriting about the phenomenon that there emerged, another, deeper level of interpretation and understanding". Caelli (2001, p.274) stated:

> *This was when I started to see that there are flows and patterns in the data that relate to each other in ways that seemed incommensurable. However, before this stage could be reached, a considerable number of challenges had to be overcome. These challenges are I believe caused by a lack of clarity in much of the phenomenological literature.*

Thus Caelli (2001) provided a useful assessment of the nature of phenomenological research. Caelli (2001, p.275) asserted that:

> *Beginning researchers are placed in an extraordinary indeterminate position, because they are required to make judgments about the phenomenological literature for which they are in no way prepared. First, they must be sure that the studies by which they clarify their approach are judiciously informed by the particular philosophical approach they have chosen to pursue.*

The method of phenomenology can therefore prove to be an incredibly challenging task for researchers engaging in this mode of inquiry because it requires that they fully comprehend the intricacies of phenomenology, before they can be reasonably expected to do so. However, when undertaking a phenomenological project, new researchers soon discover that the phenomenological method is not advanced as such (Husserl, 1931). It is that the task of each phenomenological researcher is to navigate the abundant and often times conflicting literature in phenomenology, and articulate an appropriate process, or method for achieving the aims of a particular project when the guidelines for the phenomenological methodology are nowhere clearly outlined. Notwithstanding this requirement, there exist few sources that offer concrete direction.

This situation has arisen because of the unique nature of phenomenology and its derivation from, and inextricable involvement in, the philosophical movement from which it arose. Because phenomenology is first and foremost a philosophy, the approach employed to pursue a particular study should emerge from the philosophical implications inherent in the questions. Because each differing philosophical approach grew out of a particular view of what it means to be human, and, to be in the world, it thus carries with it, the assumptions about the nature of being human and the nature of the world in which we live. In this research, where both the participants and the researcher sought to describe lived experiences, the process requires the work of all those involved in the research process. This is because lived experiences cannot be described unless the researcher, as well as the participants, attempt to put aside their assumptions about what is being discussed.

It was therefore be expected that the reinterpretation of the data would gradually engender ever deeper levels of understanding about the events that had transpired in the participants lives. The philosophical methodology of phenomenology and the method of phenomenology have to be placed in a complementary position with respect to one another. The weakness of phenomenology arises in the method, rather than the methodology. Particular attention has therefore to be devoted to ensuring that the method that has already been referred to, is robust and provides concrete direction.

3.9: The use of Community Orientated, Psychoanalytic and 12-Step Concepts as a Method to Balance the Shortcomings of the Phenomenological Research Method

In the preceding discussion, Caelli's. (2001) exposition on the challenges that need to be counteracted with respect to the phenomenological method were discussed. In light of the more pronounced difficulties in the application of the phenomenological method, it was necessary to counterbalance the impact that a seemingly unclear methodology could have on this thesis. To this end, it was believed that utilizing community psychological, psychodynamic and 12-step/spiritual schools of thought would act as a technique for refining the data that is derived from the application of the phenomenological method used in this study. More specifically, the inclusion of concepts from different schools of

psychological thought is useful because features of these approaches will assist in mitigating certain of the problems associated with phenomenology as a research method.

Like, in the case of phenomenology, the previously mentioned schools of thought involve an approach to this research that implies that the focus should be on the meanings, definitions, and interpretations which are made by the subjects of the study who have an in-depth experiential and practical knowledge of the research topic; by virtue of the fact that they have lived these experiences. In this study the research topic is recovery from mental illness. The presumption in this case, is that knowledge was created by the actual participants during the interview process. In order for the knowledge emanating there from to be surfaced and distilled, it is necessary that the research framework be conceptualized in the structure of a series of interviews, using the skills offered by psychodynamic schools of thought as well as those of community psychology and 12-step philosophy; which will convert that unstructured experience into new theory and knowledge. For example, psychodynamic philosophies attempt to access that which is unknown and inaccessible to both researcher/practitioner and the participants (Askay & Farquhar, 2006). Therefore there is consistency between the different philosophical schools of thought employed. Furthermore, the school of psychoanalysis provides structure for an otherwise and often unclear technique of phenomenology. Similar sentiments apply to the community psychological concepts and concepts that are used from 12-step philosophy. As one of the primary research interests of this study is to understand the process of recovery; it was useful to employ community psychological concepts as they serve to describe in helpful and appropriate ways the positive changes that take place throughout this process. Community psychological concepts also shift the focus away from a strictly individualistic orientation and serve to emphasize that healing from a psychological problem and/or disorder takes place in relation to other people, not in isolation (White, 2009).

Finally, 12-step principles offer a language to better understand experiences that would otherwise be alien to the reader/s of this study. Because the participants used in this study were strongly identified with 12-step philosophy; it is easy to present data that although coherent, is simultaneously inaccessible as the findings remains implicit knowledge rather than explicit knowledge. To an even greater extent than psychodynamic concepts and

community psychological concepts, 12-step concepts lend insight into the lives of the participants that were used for this study.

3.10: Data transcription

Before data analysis took place the researcher needed to transcribe the data into verbatim transcripts. Nothing was omitted from the actual interviews although there were some minor editorial changes that were required for the sake of clarity. These changes were made on the assumption that during the interview the researcher understood what the participant was saying. However in some instances some of what was said was actually unintelligible. For example most of the participants had problems with anxiety and often repeated what they were saying in a way that made the actual transcription of the data difficult. If the quote was felt to be important enough but was of an incredibly poor level in written form; the researcher made some minor changes to the quote by omitting specifically the series of 'ummmmm's' and 'ahhhhhhhh's' that were found in the interview manuscripts. The only other changes made to the data were those that protected the anonymity of the participants. For example, the name of treatment centres and psychologists that they had attended were omitted from the discussion and findings section. There was also very little emphasis placed on their professions and unless their work occupation was relevant to the findings this was also omitted from the text.

The process of transcription was done over a period of six months. Because some of the interviews were done in public spaces there was often a lot of noise coming from traffic or other people that were in the vicinity. Thus the researcher had to spend more time on certain interviews than he did on others.

3.11: Reflexivity

Reflexivity in qualitative research is a way of emphasising the importance of self-awareness, political and cultural consciousness and ownership of one's own perspective (Patton, 2002). Because the researcher plays such an active role in the process it is vital that the researcher is aware of his or her thoughts and emotions throughout the research process. Being reflexive involves self-questioning and self-understanding and, therefore, the researcher

must continually examine what he or she knows, and, how he or she has acquired that knowledge (Patton, 2002). In order to acknowledge the researcher as the tool of analysis, it is necessary for one to create and maintain a reflexivity journal.

Reflexivity journals are often referred to as “analytic memos” or “memo writing”, which can be useful for reflecting on emergent patterns, themes and concepts (Birks, Chapman & Francis, 2008). Throughout the coding process researchers should have detailed records of the development of each of their codes and potential themes. In addition, changes made to themes and connections between themes are incorporated into the final report to assist the reader in understanding decisions that were made throughout the coding process.

Once interviews were completed and the researcher began with the data analysis stages, he took notes from the transcription and interviews. Researchers can take notes by writing down any words or ideas that may be of use during data analysis in a journal or notebook. The logging of ideas for future analysis can aid in getting thoughts and reflections written down and may serve as a reference for potential coding ideas as one progresses from one stage to the next in data analysis process. Items written in journals do not have to be accurate or final but instead should contain considerations for further analysis. Researchers must take into consideration that analytic memos will assist them in the future coding of potential overreaching themes (Birks et al, 2008).

While working on reflexivity journal entries it is important to make certain that notes written in journals are different from the data. The use of italics, bolded words, and brackets will assist in showing distinctions between data and journaling. Researchers should write their reflexivity notes fully and avoid abbreviations. The use of these strategies assists the researcher in the final stages of analysis and through the process of data collection and reduction.

Auerbach & Silverstein (2003) suggest keeping a log of concerns with the research, theoretical frameworks, central research questions, goals, and major issues to help focus on the coding process. Analytic memos reveal information about the researcher’s thinking process pertaining to the codes and categories that have emerged throughout the analysis process. One of the most critical outcomes of qualitative data analysis is to interpret how

individual components of the study relate to each other. In particular, researchers should focus on observations of the population to gain an image of the bigger picture that may lead to universal observations.

After an extensive literature was conducted it became clear to the researcher that the CODs topic represented a sensitive and complicated issue. Therefore, the researcher needed to remain sensitive to the views expressed by the participants. Malterud. (2001) argues, that the researchers personal experiences and beliefs may influence what he or she decides to acknowledge as important findings. Therefore the researcher also needed to make certain that his background in CODs and substance-related disorders from previous research on this topic did not negatively impact the participants and the larger study as a whole. There are several ways that the researchers' previous experience may have negatively impacted the study. Firstly, it was possible that the researchers previous research experience in and exposure to alternate modes of conceptualising substance-related disorders may lead to the assumption that the participants, understood at all times, otherwise complex and foreign concepts. These concepts and threats are primarily orientated around alternate modes of conceptualising substance-related pathology and concepts such as CODs, dual diagnosis and psychiatric disorders.

For this reason the interview schedule did not ask participants about CODs or psychological disorders. Instead the participants were given the opportunity to speak about other psychiatric disturbances by speaking about difficulties that they had experienced during their recovery processes. Furthermore, Breakwell. (1995) claims that participants will engage in more self-disclosure with someone that they feel are similar to themselves and therefore the participants may initially feel uncomfortable at disclosing personal information about their lives when it conflicts with their particular world view, i.e. psychiatric illness versus disease related beliefs. Thus the way in which this study is presented to potential participants must be considered carefully, with the central aim of protecting participants from any negative experiences.

3.12: Ethical considerations

Ethical clearance for this research project was acquired from the University of the Witwatersrand's Non-Medical Ethics Committee (see Appendix E). To ensure that this study was ethically sound the following issues were addressed. Firstly, the participants were made fully aware of the nature of the study's aims and overall purpose. Additionally, the participants were fully informed of what their roles would be in the study. They also knew who would be able to access their interviews and the specific use of the interviews (see Appendix A). The researcher was able to get the participants' informed consent before the interviews (see Appendix B). Secondly, the researcher ensured anonymity and the confidentiality of the data as far as was possible. As the researcher himself was conducting the interviews complete anonymity was not possible; this is a characteristic of any research involving face-to-face interviews. The highest degree of confidentiality for the participants was ensured in that no-one, with the exception of the researcher, and the researcher's supervisor would have access to the interviews.

The researcher conducted the transcribing, and pseudonyms were used to protect the participants' identities. All of the interviews were kept in a safe location for the duration of the research process and will be destroyed pending publication intentions for the study. Should any questions regarding the research have arisen, the researcher's contact details were provided on the information sheet (see Appendix A).

The researcher's primary concern was the protection and welfare of the participants at all times during the research process and the potential benefits of this research needed to outweigh the potential risks. The potential risks and benefits to the participants will now be considered. Firstly although the group of participants used in this study were not regarded as vulnerable, counselling services were offered. Beyond this, each of the participants had ready access to extensive forms of professional counselling services if necessary. Even so, participants were all given the option to withdraw from the research at any stage and were not expected to answer any questions that they felt uncomfortable with. Furthermore, no questions were asked that could potentially confuse or undermine participants in any way.

There are always potential risks to those taking part in interviews but there are also certain benefits. The researcher explained to the participants that participating in the study could greatly contribute to further knowledge of a very recent and important area in substance-related treatments and on the phenomenon of CODs. They were pioneers. Given the high rates of admissions of people with CODs to treatment centres that the participants were familiar with; their contributions were considered invaluable in developing a deeper level of understanding for conditions that pose a major threat to the participants and their treatment centres for both present and future clients. Secondly, the interview process was conducted in an environment in which the participants felt comfortable, giving them the opportunity to have their views heard. Thus the researcher felt that the potential benefits of this study outweighed the potential risks of participating in the study.

The final important ethical concern was the actual credibility of the research. In order for the research to be ethically sound it was of paramount importance that the research process was valid and provided valuable information on the area/s of interest. According to Malterud (2001) qualitative research methods should involve the systematic collection, organisation, and interpretation of textual material derived from talk or observation. The credibility of the research methods used was checked by ensuring a follow-through on the research process. The meanings of the words were checked with the participants to ensure that nothing said was misinterpreted or misrepresented. Quotations used by the participants in the actual interview were used in the research findings to reflect what the participants actually voiced. The researcher kept a journal throughout the research process. This allowed him to keep track of biases and ensured that personal views and biases did not affect the final results.

It was ensured that the extracts used in the thematic analyses were illustrative of the researcher's analytic points about the data used to support an analysis that went beyond the actual data collected (Braun & Clarke,2006). In this way the theory and methods were consistent. The following criteria offered by Braun and Clarke. (2006) were employed by the researcher to ensure credible results.

Participants were informed of the nature of the study (Appendix A) and what it entailed before the interviews took place. Informed consent to participate in the interviews was acquired from the participants to allow for the interviews to be recorded. All participants received consent forms (Appendix B & Appendix C).

Participants maintained the right to withdraw from the study at any time. Although this did not happen the participants were made aware of this fact.

This research concerned itself with the protection and welfare of its participants and as such, every effort to prevent stress, pain or discomfort that could be caused to the participants by the study was made. The researcher was aware that the recall of past experiences could cause some degree of distress to participants and so free counselling phone numbers were provided on the participant information form in the event of participant distress. In the event of any of the participants feeling that they require any counselling services, important contact details were made available (Appendix A).
All questions raised by the participants were answered and all of the potential effects of the research were discussed.

Finally, the researcher was aware at the outset of the study that some of the participants might feel uncomfortable at having their interviews kept in the university Library. It is clearly explained in the participant information sheet that no identifiable material could be used to connect participants to the data they provided. For example, their names were kept secret. Pseudonyms were used for all participants. In this way, all information obtained by this research remained confidential and participants had the right to anonymity where it was possible. However, since the researcher was interviewing the participants, complete anonymity could not be guaranteed.

Chapter 4: Findings and discussion

4.1: Introduction

After the data analysis the findings were discussed under three master themes, each of which constitutes an independent section. Within each of these sections several sub-themes were used to illustrate the central themes relevant to each chapter. Each chapter also offers some introductory thoughts on the nature of what is to be discussed as well as brief summaries of the key findings at the end of each chapter.

As this is a qualitative study it was useful to combine the discussion and findings section of this project because this combination allowed for the findings to be combined with previous research so that reader would have a greater understanding of the context out of which these questions arose and an appreciation of the findings presented. The forthcoming section is informed by the research questions in Chapter Three and will focus predominantly on (1) The common elements in the experiences of those who have recovered from a COD and substance-related disorders, (2) the therapeutic aids that have been helpful to the participants; and (3) the factors that have had a detrimental effect/or acted as a barrier to the participants' processes of recovery. Because the primary focus of this study was to consider the lived experiences of these individuals, several other important areas that were emphasised by the participants were also discussed.

Three master themes were explicated from the data collected from the semi-structured interviews. The terms "master themes" and "sub-chapter" are used interchangeably refer to the same thing. The first master theme or sub-chapter discusses the meaning of suffering in substance-related disorders. This sub-chapter describes the different types of suffering that people with these disorders go through and the potential meaning and utility that the consequences associated of having CODs yield to the individual. The consequences that are described in this section are spoken about primarily in terms of substance-related problems. It also discusses some of the more complicated consequences of living with these kinds of disorders including a deterioration in mental functioning, a defect in affect regulation and consequently the inability to behave in a way that these participants later viewed as correct or 'better'. Thus, this sub-chapter deeply engages with the destructive potential of the substance-related aspects of a COD and, how, in spite of these consequences the driving

forces and pathology underlying these disorders continue to propel the individual towards self-destruction.

The second master theme in this thesis provides insight into some of the factors that facilitate what the researcher describes as 'the necessary change in trajectory'. This term refers to the point at which the participants who were involved in this study managed to achieve abstinence. This term denotes the starting point of the recovery process and the individual's journey towards health. It also provides a simple reference point that can be used by the reader to make sense of this complex journey towards health. The second master theme refers to a new era in the participants lives and discusses both how they reached this point in terms of what motivated them as individuals to stop their substance-use and what mechanisms defined these attempts to stop their substance use in comparison to their previous attempts and failures. The first part of this chapter is primarily concerned with the earlier phases of recovery; a phase which was often referred to as distinct from later and/or distinct from longer-term phases of recovery. In so doing, specific emphasis is given to how the participants have chosen to define their recoveries. Each definition provided in this sub-chapter was viewed in a unique way to ensure the accuracy of the participant's reflections on this complex process.

Furthermore, the starting point that is referred to is viewed specifically in the context of complete abstinence from all substances, as all of the participants previously suffered from at least one kind of substance-related disorder. The strategies that the participants utilised in their attempts to recover were all deeply embedded in the 12-step paradigm with every action that they later took, needing to be reconciled with this philosophy. This sub-chapter attempts to unpack components of what is necessary in actually arresting and/or discontinuing substance-use. Although this aim provides useful insights into some of the factors that facilitate the process of recovery, it should be further distinguished from the factors that are required to maintain and enhance this process in the long term.

The second aim of this sub-chapter is to describe some of the factors that facilitate longer-term recovery from CODs and substance-related disorders. Describing the factors that facilitate longer-term recovery required a discussion on some of the factors that are protective to the recovery process as well as individual factors that were relevant to treating the participants' disorders.

The final master theme is entitled 'Die Soegenden'; that is, "the searching people". Through the use of several sub-themes the concept of recovery is explored in great detail. The participant's reflections on what was detrimental to their recoveries was also included. Several frameworks were used to interpret some of the underlying dynamics and challenges that CODs pose to the life of the individual. Specifically, community-orientated concepts were used to discuss several concepts in the process of recovery. In the context of a search for meaning the factors that facilitate recovery from substance-related disorders and/other psychological disturbances as well as the factors that are not helpful to these individuals are discussed.

Finally, the last master theme discusses the factors that constitute potential threats to the ongoing health of these individuals. Individual differences in the type and severity of CODs were also discussed throughout all three sub-chapters. This section is discussed primarily in relation to the CODs phenomenon, with specific emphasis on the threat that untreated mental illness can pose to the recovery process.

The master themes are titled as follows:

(1) The meaning of suffering in substance-related disorders,

(2) A shift in trajectory

(3)We are "Die Soegenden": The searching people

Although it was not possible to describe every dynamic related to CODs, extensive effort was made to (1) provide valuable information on the various manifestations of substance-related disorders as the expression of underlying pathology; and (2) providing insight into the internal world of the participants to account for differences between the participants. Discussing individual differences in terms of thoughts and perceptions helps to contextualise the matters discussed in this study in an in-depth manner and in a way that is meaningful and useful.

4.1.1: Part 1

The Meaning of Suffering in Substance-Related Disorders

Introduction

The primary aims of this thesis were to describe and isolate the factors that facilitate recovery from CODs and substance-related disorders. In light of the rich data that was collected during the data-collection process the researcher was able to reach very far back into the personal experiences of the participants. Thus, it was decided that the active substance-abuse phase of the participants' lives could provide very important insights into phenomena that were of interest to this study. Doing this also provided the reader with a 'starting point' to help orientate themselves in attempting to interpret and understand the insights that follow.

Broadly speaking, these participants all appeared to have suffered terrible consequences as a direct result of their substance-related disorder. However these consequences differed in severity; with some of the participants suffering considerably more negative consequences in relation to their substance use. These consequences included terrible losses in their lives that ranged from significant financial problems to complete breakdowns in their family units.

After a careful analysis of the interviews the first theme emerged. This theme was orientated around the nature and function of events related to their personal histories. What became clear from very early on in the data analysis period was that the events that transpired during the 'active-addiction' period were described by the participants as being qualitatively distinct in terms of the influence that they exerted in the participants lives. That is to say that certain events were imbued with more emotional importance than others (Cunningham, Sobell, Sobell & Gaskin, 1994).

Many of the participants spoke about a state of total despair preceding their desire to get help for their problems. However, these very serious life conditions were also accompanied by a set of lesser consequences. The researcher utilised Chen's. (2010) notion of primary and secondary suffering as a theoretical framework to help categorise these different sets of lived experiences. Importantly, Chens. (2010) framework is spiritual in nature. It was

decided that using this framework was appropriate because it shared similarities with certain of the spiritual principles embodied in the 12-step program. These lesser consequences which were seen as peripheral and symptomatic of underlying problems were spoken about in terms of Chens'. (2010) notion of primary suffering. The researcher described these events in a sequential fashion, as this approach was chronologically accurate and allowed these events to be viewed along a continuum.

4.1.2: The vicious cycle

The first type of suffering that is discussed is termed primary suffering (Chen, 2010). Primary suffering refers to a range of events that are characteristic of the addicted individuals' lifestyle; as opposed to events that are typically associated with significant change (APA 2000; Chen, 2010). The participants referred to these events as being different from the events that later motivated them to seek help. Owing to the extensive amount of data collected the researcher could not describe every interview in detail. Through the use of sub-themes the researcher drew on several interviews that supported the ideas put forward. These difficulties were described in relation to their substance-related disorder. However differences in the severity of the consequences that the participants underwent were discussed in the context of what suffering from different from different CODs is like.

A synthesis of the participants and researchers views suggested that these difficult periods in the participants' lives were related to: (1) the attainment of the substance/including alcohol, (2) to the maintenance of the substance-related behaviour and (3) a state of ambivalence and a set of reservations that the participants had in relation to their substance abuse. These specific events should be viewed in the context from which they arose. Specifically they should be viewed in the context of recovery from CODs. Although individual differences in the type and severity of various CODs are described, these experiences should not be viewed as a framework through which to describe different types of CODs and substance-related disorders. By viewing the participant's experiences in this way, the possibility of looking at these kinds of ordeals as being a necessary prerequisite for illness and recovery is reduced. However where it was appropriate, differences in the severity of a certain COD were discussed.

In relation to being asked about some of the changes that had transpired between their active-abuse phase and the point that they were now at in terms of their recoveries; the participants all spoke about some of the negative consequences that they had experienced during their active-addiction phase. To begin, Garth spoke about how difficult it was to repair the damage that he had done to his professional career. He said:

> *Dealing with the consequences of the way I had managed my finances you know I was a financial holocaust.*

Garth has been abstinent for 7 years and lives a productive and successful life. However, in relation to his active-addiction period, Garth described a situation of complete financial ruin (Colpaert et al, 2012). He explained that the nature of his problems went much deeper than substance-use. He felt that the financial implications of his substance use were problematic but not overwhelming. He felt that these consequences were not a rationale for him to seek help.

Being unable to control his substance-use, Garth described the way that he had to participate in illicit activities that would greatly complicate his life later on. However, this man viewed his financial setbacks and losses of his active addiction phase as peripheral to the reasons that later motivated him to seek help. Thus, this account denotes a situation where in the 'ball was still rolling' rather than a completely desperate situation. Gideon spoke about similar events taking place during the last ten years of his active-addiction phase. He said:

> *In that period I had three financial rock bottoms.*

Gideon did appear to be disturbed by recalling events that entailed him losing so many of his material assets. He believed that it was simply a consequence of the lifestyle that he was living. The researcher perceived in his tone a 'live by the sword; die by the sword' attitude towards these particular events. His tone did not betray any sense of guilt and shame regarding this phase of his life. His accounts were construed in a tone of simple honesty and acceptance. He felt that what he had been through was simply the result of a particular lifestyle (Colpaert et al, 2012). However, given the similarities in the stories told by the participants, it did not seem likely that becoming financially unstable was simply the result of poor decision making or bad luck. Importantly, Garth was one of the participants that did

not openly speak about a history of psychiatric problems outside of his problem with substances. It was possible that he did not in fact know about the existence of any psychiatric problems in life beyond the emotional manifestations of his CODs and substance-related problems (Green et al, 2008). Therefore, it was not unusual that he did not attribute his previous state of financial instability to CODs or substance-related problems. Because the data was based on self-reports, the exact nature of their psychiatric disorder could not be completely ascertained even though the participants had all been rehabilitated. However, a trend that has been found in research regarding CODs is that health practitioners working in the substance-related field demonstrate a tendency to only refer to the existence of a COD when the COD is severe (Kadden et al, 1995).

To further illustrate how the participants, as people with CODs and substance-related disorders, experienced financial instability, the researcher drew on another 'case in point' scenario using his interview with Edgar as an example. Edgar described some of the financial problems that he had accumulated over the course of his active addiction. He said: "I had R200 000 debts when I came in to recovery". In his interview, he spoke about material changes to demonstrate the depth of certain material changes that had later taken place in his life (Laudet & White, 2010).

Like Gideon and Garth, Edgar felt that the financial losses that had resulted from his addiction were of secondary concern. During his interview, Edgar demonstrated the severity of his problems as well as the depth of change that had occurred since then by comparing the active-addiction phase of his life to his life now. Edgar also construed these events in a matter of fact tone. For these men, the financial implications of their lifestyles were not a sufficient rationale to discontinue and/or deal with any possible underlying problems (DiClemente, Schlundt & Gemmel, 2004).

However, specifically where finances were concerned, Edgar had experienced very severe financial hardships. This is not to say that his financial hardships were worse than either Garth or Gideon. However, Edgars' struggle to manage his finances was a problem that persisted years into his recovery. Importantly, Edgar was one of the participants that spoke openly about depression that he had experienced throughout his life. Edgar said:

> *I had depression uh, periods where I was on anti-depressants. I was on anti-depressants, probably two three times in my life for periods of between 6 months to a year and I tried, I always tried very hard to get away from it because it uhh but at the same time accepting that it had been necessary at certain stages for certain periods*

Edgar shared a similar account wherein he explained that he had suffered from depression intermittently throughout his life. He explained that this began after he had suffered a heart attack. He said:

> *I had depression uh, periods where I was on anti-depressants. I was on anti-depressants, probably two three times in my life for periods of between 6 months to a year and I tried, I always tried very hard to get away from it because it uhh but at the same time accepting that it had been necessary at certain stages for certain period uh so ummm I don't like psychiatric approaches to recovery, I don't like over medication of people because I think you you're not really moving ahead if you're just numb your emotions.*

Edgar took responsibility for the fact that under certain conditions, he would need to medicate for his depression. Here Edgar highlighted the need to manage symptoms in one form or another as a necessary part of his recovery (Shrank &Slade, 2007). However, in recent years, his depression had improved significantly. Edgar also expressed some important personal views about his recovery wherein he explained that he did not like psychiatric approaches to recovery, which in this context, referred to medicating people for their psychiatric conditions. This was because he believed that in his recovery it was important for him to be able to experience a full range of emotions in his life. Edgar touched on a topic for which many members of 12-step Self-help group's view as controversial. That is, providing people with a history substance-dependence, with anti-depressants and other forms of medication. Recent research suggests that people with a substance-related disorder and a psychiatric disorder (COD) are at the greatest risk for not taking prescribed medication for their disorders (Magura, Laudet, Mahmood, Rosenblum & Knight, 2010). The consequences for this can be severe (Fabricus et al, 2008). It is clear from the characteristically disorganized and unmanageable lifestyles described during the active substance-abuse phases of the participant's lives, that this would have implications for

adherence to medication regimes. The degree to which the participants required psychiatric medication varied (Fabricus et al, 2008).

Thus, Edgar was faced with the additional burden of dealing with a depressive disorder throughout his life. Edgar had take responsibility for the fact, that under certain conditions, he would need to medicate for his depression. Edgar, thus, highlighted his need to manage the symptoms of his disorder in one form or another as a necessary part of his recovery (Shrank & Slade, 2007). In recent years, his depression had improved significantly. In contrast to the significant financial problems that Edgar had faced, both in his active addiction phase and his recovery, Garth stated:

> *I never had to hold up a bank in order to get money to score drugs but committed credit card fraud.*

Although Garth had been through significant financial challenges, he had managed to achieve a state of stability later in his life. In the context of this section, events related to financial losses served to describe a breakdown in functioning rather than an end point of complete self-destruction. However, differences in the degree to which the participants suffered financially were evident in the participants' accounts. These events were symptomatic of other disturbances in their lives (Fabricus et al, 2008).

Although most of Garth's accounts were spoken about with an underlying earnestness and clarity, Garth described what had happened in a somewhat humorous manner. The researcher attributed this to the fact that Garth was describing a period in his life wherein there was still a perceived benefit to the substance-related behaviour, as well as a certain degree of pleasure associated with it. Thus, this period of Garth's life was in fact characterised by a degree of ambivalence (Skinner & Aubin, 2010).

Garth was aware that his substance-related behaviour was harmful to him and had begun to cause him significant distress, but, he did not yet feel motivated to attempt to completely arrest his substance-related problem. Instead, he employed a variety of mechanisms in an attempt to quell and manage the consequences created by his substance-related behaviour. He continued:

I would use different mechanisms, and act out in different ways in order to ensure that I was going to white knuckle it out, and then the cycle would begin again.

Garth described the way in which he intermittently reached points where he would view his substance abuse as problematic and would in turn employ a variety of mechanisms designed to help him abstain from substances-including work and relationships. He also described how this means of coping was insufficient and caused distress to his life. Ultimately, these strategies were insufficient in helping him to completely abstain or moderate his pattern of using substances in the long term (Norcross, Krebs & Prochaska, 2011).

As a means to control and manage their substance-related problems, many of the participants described a process of 'cross-addiction'. In Garth's case he explained how his hope diminished as his awareness grew around how these events would play out. This negative cycle was characterised by a great degree of frustration and hopelessness. The researcher felt that this was an important area that should be explored further because it was related to many other constructs that were relevant to this study. The first has already been mentioned. That is, a certain degree of ambivalence that many of the participants experienced in relation to what they felt about their substance-use and the destructive potential that this created for them (Foster, Neighbors & Prokhorov, 2014; Khantzian, & Treece, 1977). Like Garth, Edgar also felt that transferring his addiction into a different focal point or area/s would help him to manage the ever-increasing problems that his active substance-abuse was causing to his life. Edgar said:

I chose cross addicting to gambling because I could deal with the consequences.

Both Garth and Edgar employed a method of cross-addiction in an attempt to manage the negative consequences that had begun to unfurl in their lives (Norcoss et al, 2011). Edgar mentioned in his interview that he had maintained certain reservations regarding the impact of his substance use, and, would at times abandon his decision to abstain from substances. These reservations were coupled with an apparent uncertainty about the true effect that substance-use was having on his life. However, Edgar chose to continue to manage his illness in ways that seemed to work temporarily, but, always ended with similar

outcomes. Rather than deal with these problems directly, Edgar also employed a method of cross-addiction as a means to control the substance-related problem. He continued:

> *I didn't want the drugs and the alcohol. The consequences were too serious. For me gambling was just a financial loss, which I could deal with.*

Evident in Edgar's comments here, was the awareness that, for him, using substances was a dangerous practice. Having the resources to cross-addict to gambling, Edgar chose to abstain through gambling. The participants shared much about material losses in their lives in relation to the question of "Tell me about your life now as compared to your life before your diagnosis*".* Many of them suffered financially and lost many material assets such as cars and housing. Despite these terrible consequences they all continued using substances.

This seemingly meaningless suffering perplexed the researcher, and required that he explore the notion of suffering in addiction further. Early pioneers in the treatment of alcoholism, such as Dr. Harry Tiebout (1957a), posited that arriving at a point wherein one feels defeated by his or her addiction is meaningless without surrender. Thus, someone who is addicted to a substance can live a life characterised by many series of losses without relinquishing his or her relationship with the substance. It was unfortunate to observe that this was the case in every interview.

If these deductions were true, then, it obviously was not simply a matter of being beaten into submission by addiction to substances? However, if this was true, then the researcher wanted to make certain that he had attempted as rigorously as possible to understand what the underlying essence was with regard to why these individuals went through so much suffering before seeking help.

These concerns largely pertain to what the substance and/or substance use actually represents to the participants. This is a matter that will be discussed rigorously throughout the next few sections. First, the researcher drew further on Tiebouts' (1957b) work, which focused primarily on some of the inner conflicts characteristic of people with substance-related disorders.

As an early pioneer in the treatment of alcoholism Tiebout (1957b, p.311) states, "Characteristic of the so-called alcoholic is a narcissistic egocentric core, intent on

maintaining at all costs its inner integrity". The intention behind using this quote was to illustrate that where actual dependence and/or addiction is concerned there is the overwhelming and clearly observable capacity for the individual to protect their substance-related behaviour at any expense. This claim was supported by many of the participants' accounts wherein they described the arrogant and aggressive manner in which they lived for many years. For example Hanna said:

> *I was always trying to justify and defend my position, which was really untenable, I was self destructive, and I was completely committed to making my point be heard and not listening to everybody else.*

There were several other similar accounts. Over the past six years of her recovery, Hanna had become aware of the extent to which she was in denial of some of the problems that she was experiencing. Her account also suggests that she was aware at some level that her problems were self-imposed (Alcoholics Anonymous, 2001). Thus she explained her means of interacting with the world around her as, 'untenable'. It therefore could not last and a failure so to speak was inevitable. As Blaine and Julius (1977) posit, the attempted solution for a cure to other underlying problems is impermanent and cannot succeed. To contextualise this matter, the researcher drew primarily on the participants experiences. He also explored some early psychoanalytic authors who were influential in describing the chief conflicts characteristic of those who are understood be substance-dependent.

Kohut (1972, as cited in Dodes, 1990) describes the addicted person's capacity for and the role of narcissistic rage in addiction. This author maintained that narcissistic rage can be distinguished from other forms of aggression by its unrelenting compulsion and complete disregard for reasonable limitations (Daniel, 2012). This was clearly demonstrated by the participants pre-occupation with substances and the fact that they kept on abusing substances in spite of the serious consequences that they were experiencing (APA, 2000). After having reached a point of financial ruin; these individuals' capacity for self-destruction continued and increased even in light of their awareness that they could not master their substance-use. Discontinuing their substance use did not appear to be a rational option for them. In fact it did not occur to them that it was an option at all (Dean, Khono, Morales, Gharemani & London, 2015).

With these thoughts in mind, the researcher returned to the voice-recorded transcripts to see whether there was something that he had missed. Earlier it was mentioned that Garth expressed a sense of humour around the financial setbacks that he had experienced as a result of his addiction. Research has supported the role that ambivalence can play in those people who become addicted or have the capacity to become addicted. For the purposes of this study ambivalence refers to, "the simultaneous existence of opposite feelings, attitudes and tendencies directed towards another person, thing or situation" (Woody, 1971.p.176).

Ambivalence in the participants was demonstrated by the many years of meaningless self-harming behaviour. It was further evidenced by the conflicting knowledge that the participants had of being aware that the substance-related behaviour was causing harm to their lives and that their somewhat counter-intuitive attempts to manage the behaviour were creating secondary addictions. The fundamental danger of such a conflict was that this state of ambivalence acted as a propelling force towards a greater level of addiction in the participant's lives (DiClemente et al, 2004; Krystal, 1971).

It also brings to light the well-documented phenomenon of denial that is common in addiction literature. In this instance, denial refers to a psychological system that is created around the harmful behaviour (Johnson, 1999; Stodard Dare & DeRigne, 2010). The manifestations of denial. For some of the participants, denial manifested itself in the form of failing to acknowledge the harm that substance-use was causing in the participants lives'. For others, this mechanism was evident in the way that certain of the participants used to avoid certain problems in their lives'. For example, in discussing some of the changes that had taken place in his life, Brian explained that he experienced great relief in the fact that he no longer had to run away from his problems. He said:

> *From being clean and clean headed and you know making decisions based on my experience and based on being straight instead of making the fucking easy decision to get out of a situation you know, I' m quite happy to make decisions and bare the consequences if they come, and ummm and I actually enjoy that, I actually enjoy facing that now. I always used to run away from stuff so you know what, life is fucking great. It wasn't always so, it was difficult at the beginning but now it's pretty good.*

Thus, in his recovery, Brian had come to accept the nature of his past behaviour. More specifically, he understood that he was not dealing with his problems. In the context of this study, denial constituted a means of coping with the way that the participants were living their lives, which, allowed the participants to continue with the harmful behaviour in spite of its detrimental effects. Denial, in ordinary English usage, is asserting that a statement or allegation is not true. The allegation that the participants were received before they managed to become abstinent was that they were addicts. Denial can be thought about in scenarios wherein a person is faced with a fact that is too uncomfortable to accept and rejects it instead, insisting that it is not true despite what may be overwhelming evidence. The concept of denial is particularly important to the study of addiction (Dean et al, 2015; Watts, J., & Hook, 2009). Certain theorists such as Anna Freud described denial as a mechanism of the immature mind, because it conflicts with the ability to learn from and cope with reality (Dean et al, 2015). Hanna's accounts demonstrate another example of the destructive potential of denial. She said:

> *I've been alcoholic and bipolar for 31 years and I kept getting locked up in mental institutions and jails for a long time.*

It had caused her humiliation and anger, however, she continued these patterns of behaviour for over three decades before Hanna questioned what was really going on with her and to take steps to begin to address her problems. She stated:

> *I wasn't really convinced that was a problem.*

Importantly, Hanna evidenced what can be considered a severe COD (Singer et al, 1999). In this instance it was bipolar disorder and alcohol dependence. This ongoing and very negative pattern of self destructive behaviour continued for many years**.** Bipolar disorder refers those people who experience both depression and mania. These episodes of mania are often linked to depressive episodes (Burke, 2009). Being both alcohol-dependent and bipolar meant that Hannas' COD would be looked at in terms of quadrant 1 of the Four Quadrant Model. Quadrant 1 of the four Quadrant Model suggests that individuals falling into this category typically suffer from a primary mental illness Axis 1 diagnosis of chronic schizophrenia or a major mood disorder including bi-polar disorder and/or major depressive disorder (MDD), and/or Axis II diagnosis of severe personality disorder including antisocial

personality disorder (ASPD) or borderline personality disorder (BPD) combined with chemical dependency involving alcohol and other drugs (Singer et all,1999). People who fall within this category are recognised as suffering from severe mental illness. It has also been established that people with co-occurring bipolar disorder generally undergo poor treatment response, unemployment, homelessness and prolonged disability (Compton, Cottler, Jacobs, Ben-Abdallah & Spitznagel, 2003; Singer et al, 1999). Hanna's account fit this profile in many respects as she had remained unemployable for many years and had lost the ability to function in everyday life.

It is not uncommon for substance-dependence and bipolar disorder to occur together. In the National comorbidity Survey (NCS), which is one of the largest epidemiological studies on psychiatric comorbidity, it was found that 60.7% of people with bipolar 1 disorder had a lifetime diagnosis of substance use disorder (Drake et al, 2004). Differences in the severity of CODs are important because more severe CODs can result in greater and more complicated problems (Fabricus et al, 2008). Similarly, it is important to understand the relationship between co-occurrence of specific disorders because this has important implications for treatment. Outside of her substance abuse, Hanna had been institutionalised on many different occasions. Hannas' frequent institutionalisation was not limited to only psychiatric settings but also to the legal system.

These frequent admissions to psychiatric institutions and to jails were indicative of an inability to cope with lifes' demands. Hannas' account demonstrates that living with severe CODs can be more disabling than living with a less severe COD. In spite of the threat that having a COD poses to the life of the individual Hanna had worked very hard to deal properly with her co-occurring disorder to the extent that she said, "I don't consider my bipolar a hindrance anymore". Hanna had received extensive psychiatric treatment for her bi-polar disorder and had attained the correct combination of medication. Hanna was also only 6 years abstinent and/or into her process of recovery but she had taken massive strides in her life and was relatively stable with a profound willingness to do what was necessary to continue to recover (Goodman, McKay & DePhilippis, 2013).

In the context of this sub-theme primary suffering is described in terms of, but is not limited to material losses. Most of the participants felt that financial losses were important because

financial instability appeared to be a common denominator that precipitated the suffering that followed. However, certain of the participants such as Hanna did not refer to financial losses and instead felt that her repeated institutionalisation and legal problems precipitated more severe events in her life. The quotations provided from the interviews demonstrate that primary suffering in the form of material losses is not a vehicle for change in and of itself in people who become addicted to substances.

Beyond describing some of the problems that the participants underwent before becoming abstinent several other ideas were discussed. The first was the notion that substance-abuse is indicative of underlying pathology. During earlier periods of their active-addiction phases, the participants collectively felt that they were in denial of their problems. Some of the participants chose to adopt secondary addictions through cross-addicting to behaviours that proved to be harmful in the long term. One of the participants explained that part of his recovery was orientated around coming to terms with the fact that they had a disorder/s and taking steps to deal with it. However in reality, the vast majority of individuals attending these SHGs do not actually receive a diagnosis of a disorder other than the substance-related disorder. Instead, once being referred to the SHGs of AA or NA or both, they are informed through other members of these SHGs, that they have a disease (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2001). Other psychological ailments that group members experience are often explained in terms of the manifestations of this disease or in terms of substance-induced symptoms (Bruce et al, 2005; Flynn & Brown, 2008)

It has already been discussed in Chapter 1, in the literature review, that by definition, CODs cannot be present without the individual suffering from at least one kind of substance-related disorder. Furthermore, for a diagnosis of co-occurring disorder to be made, it also requires the presence of at least one type of psychiatric/mental disorder (Fabricus et al, 2008). Because the individuals constituting the group of participants used for this study were all diagnosed with substance-dependence in one form or another, at a theoretical level, these individuals could only fall into one of two categories. That is severe mental illness co-occurring with substance-dependence or less severe mental illness co-occurring with substance-dependence (Singer et al, 1999).

The researcher chose the constructs of ambivalence, denial and narcissistic rage to theoretically contextualise and understand the notion of primary suffering. The accounts so far provide evidence of this. Even after having reached a point of financial ruin among several other negative consequences, these individuals' capacity for self-destruction and their inability to master their substance-use was not a rationale for them to discontinue their substance-use. Thus, in these particular cases, the negative consequences that the participants endured should not be viewed as motivating forces that propelled the participants towards a process of recovery.

The consequences therefore that are commonly associated with pathological substance-abuse do not appear to significantly alter the substance-related behaviour. This is unfortunate as it suggests that something else is required for the addicted individual to break the pattern of abuse. In conclusion of this sub-section the following points are put forward.

1) The participants demonstrated a degree of ambivalence and denial in the initial years of their substance-abuse.

2) Many of the participants chose to 'cross-addict' to other behaviours that eventually exerted a destructive influence on the participants' lives. This further demonstrated the denial around their addictions in the sense that believed that they could somehow manage it by creating secondary addictions.

3) The theory presented in this sub-section suggests that underlying psychological disturbances result in an excessive need to abuse substances and employ several other mal-adaptive coping strategies.

4) The severity of CODs can result in more complicated and more severe problems.

4.1.3: Addiction as an estrangement from the self

The accounts provided so far demonstrate certain aspects of the destructive nature of addiction. Unfortunately these consequences were not limited to material losses. The process of becoming addicted resulted in losses that the participants considered more serious than those losses associated with primary suffering. This section now discusses the psychological impact that chronic substance use can have on an individual.

Over extended periods of remission, many of the participants' realised that their pre-occupation with substances had inhibited them from developing in vital areas and that they actually did not know who they were as people in terms of their personal preferences and relationships. As has already been discussed these consequences were primarily spoken about in relation to their substance-related disorder. However, while analysing the interviews, the researcher found that the participants regularly referred to the function that substance use performed in their lives. Thus this section shares a dual focus. The first pertains to a distinct form of suffering that the participants attributed significant meaning to. The second focus point relates to some of their thoughts on why they needed to go to the extreme in the first place. They related these struggles to challenges that persisted, even in longer-term recovery. The researcher felt that a better understanding of this was integral to providing key insights into what had actually transpired before finally becoming abstinent. Martha spoke about the months preceding being admitted into a treatment centre. She said:

> *You' re in that state of either being up or down; unsure of who you are, just basically not able to figure out where you're going, thinking that you need to be somewhere, thinking that you need to achieve something that you couldn't possibly achieve.*

This is the way that Martha felt in the final months of her active substance abuse. At first glance, the researcher was puzzled by this account. It seemed obvious to interpret and disregard this account in terms of substance-induced symptoms, as Martha was describing a period in her life where she was in a critical state. Because the researcher was aware that the abuse of virtually any mind-altering substance can lead to a range of chemically-induced symptoms he felt inclined to explain what Martha said in terms of substance-induced symptoms (Zweben et al, 2004). However, after revisiting her interview and several others it became clear that Martha was describing something more specific. Martha was also referring to a period during which she was not intoxicated or high (Alcoholics Anonymous, 2001).

In describing how her life had changed after becoming abstinent; she spoke extensively about the effect that substance-abuse had on her life. Her comments here demonstrate much more than substance-induced symptoms and extend to the point where psychologically she had lost the ability to make sense of things in her life. She described

being in a state of profound confusion. She would vacillate between feeling either 'good or bad'. When she wasn't using substances she experienced negative moods and a sense of hopelessness. Furthermore, rather than describing being high as a pleasant experience, she described it as being the only alternative to what she was feeling (Garland, Carter, Ropes & Howard,2012; Johnson, 1999).

She had also lost the capacity to feel 'in-between' feelings. Thus a process of radicalisation of her feelings had begun (Khantzian & Treece, 1977; Wurmser, 1977). It became a situation where what she had to deal with emotionally was simply too unbearable and using substances was the only alternative that she was left with.

For this woman it was an either/or situation wherein trying to remain sober was too painful and using substances brought on too many other negative consequences. It was a desperate dilemma. She also explained the terrible sense of loss that she had previously experienced in relation to her dreams and ambitions. She explained that there were a great many things that she had wanted to do in her life. Because of her substance-use she was not able to pursue any of these ambitions and dreams. Thus she lost the ability to interpret the way that she was feeling and to persevere with goals in her life (Wilens, Martelon, Shelley-Abrahamson, Biederman, 2013). Building on Martha's experience, Sara in her interview related being in a similar state and explained the terrible sense of loss that she had experienced once she became abstinent. She said:

> *It was incredibly depressing to see what I hadn't actually done with my life.*

Sara also suffered from co-occurring bi-polar disorder but had been diagnosed much later in her life. During the initial stages of her recovery she had not received adequate treatment for her COD even after many years of being abstinent. There were considerable differences in the course their co-occurring disorders had taken. After a severe trauma that Sara had undergone in a car accident Sara had sought professional help; although the assistance was provided by her work. Consequently she had undergone some terrible experiences with health professionals that had left her feeling sceptical of the help that she could actually derive from seeking psychiatric assistance. She said:

> *Right after the car accident I went to this ridiculously bad therapist. He was one of the worst therapists. He was strict and judgemental of me and I wanted to run a mile*

but my work had provided this as their form of care but he was dreadful and I was very traumatised by the accident and I didn't address it.

Sara explained that after her car accident her work had provided her with a psychologist. In a time of great need and where in things were already unravelling in her life, Sara obviously needed a lot of support. However she felt misunderstood and that her therapist was too hard and judgemental on her, further enforcing the idea that she could not benefit from psychiatric or psychological assistance (Brady & Sinha, 2005; McGovern et al, 2006). Instead of receiving much needed support in her life; Sara left therapy feeling judged and misunderstood.

Sara believed that she had needed more guidance and support earlier on in her recovery. One important idea that her account suggests is that abstinence alone is insufficient to deal with other disorders even when this abstinence is accompanied by a support group. Such a statement must of course, be scrutinised with knowledge of what type of COD she suffered from and the implications that this could potentially have on her life. After having been treated and learning that she was in fact bi-polar, Sara went through a period of despondency explaining that her manic episodes allowed her to do great amounts of work and gave her massive creativity. Along with her diagnosis she had begun to medicate like Hanna and found the effect of the medication inhibiting. There was however a greater level of acceptance regarding her condition which she had decided was a part of her life and something that she needed to take continued responsibility for.

Alternatively, Hanna had received comprehensive treatment for her bi-polar disorder from very early on in her recovery. She still maintained, "It serves me well to see a psychiatrist once a month". Although Hanna was not always content with the way that her medications made her feel she always made sure to treat her disorder accordingly. In contrast Sara never had access to effective treatment regarding her disorder. She said," I was one of the few people that didn't have any help when I got into recovery". In her thirteenth year of recovery Sara suffered from a nervous breakdown after her motor vehicle accident. Fortunately she had survived the accident without much physical harm but the trauma of being in an accident set off a train of events that led her to have a nervous breakdown after which she had to be temporarily institutionalised. In retrospect, she considered the

experience necessary in coming to terms with some of her underlying problems. However the experience was still raw and very frightening.

Both Martha and Sara described how ambitions and phantasies regarding the lives that they had once envisioned began to resurface. It seemed that part of the emotional turmoil that they had experienced was essentially in experiencing these ideas and phantasies of the expectations of the life that they felt they should be living while simultaneously being aware that they were not capable of pursuing these things. There was thus a conflict and a resulting tension. At this point it became clear that there was no longer a perceived benefit to using substances. Hanna also explained the need she experienced for using substances while at the same time being aware of the destructive consequences that they had on her life. She said:

> *I would go through that stage, have a drink and get that cockiness back and either I was the boss or I was screwed, there was no in-between, either I was in charge, putting people off or I was feeling terrible.*

The global quality of Hanna's accounts shared similarities with Martha's earlier comments. Eventually they were placed in an "either or" position on an emotional, psychological and behavioural level. The pain associated with these repeated experiences was derived from the awareness of knowing that their attempts at coping were no longer beneficial while at the same time feeling completely powerless to change it (Alcoholics Anonymous, 2001). Kayla's comments support this account. She explained that before coming into recovery she had no awareness of her internal life in terms of her hopes, dreams, interests, spirituality and or emotional experiences (Garland et al, 2012). Being unable to interpret what was going on inside of her propelled her towards substance-use. She said:

> *When I was in active addiction I was unaware of what was going on with me.*

Hanna also began to experience the world in an extreme way. She described how substance-abuse touched every aspect of her life. She spoke about the disillusionment she experienced when the substances could no longer perform the role and function that she wanted them to. She had reached a point where she could perceive the paradox of her addiction. On the one hand substances made her feel better; on the other, she knew

nothing else outside of substances to help her cope with what she was undergoing. She said:

> *What I realised was that all along these feelings of euphoria and just this deep love and connection to the universe was actually not real.*

Like Martha, Hanna described a growing sense that her life was not real. So far had her pre-occupation with substances infiltrated into her life that she could no longer bracket off or compartmentalise the effects produced by the substance from who she was as a person. The line between a pleasurable activity and her requirement for coping with life was now blurred. As opposed to her earlier years of substance-use, which she associated with many positive memories, she was no longer able to make those same attributions about what she was feeling or her experience of the world. She could no longer connect what she was going through to the actual ingestion of substances.

Similarly, Kayla had begun to connect major meaning systems in her life such as her spirituality with her substance use (Chen, 2010). She had in essence begun to mistake her 'chemically induced' spirituality for her real beliefs (Campbell, 1991). The pain she felt once realising this took the form of a profound disillusionment and sadness at the fact that she had in a sense been 'tricked' by the effect of the substances. To further demonstrate Brian said:

> *When I went into recovery I mean I had lost everything; I mean I didn't know anything, I didn't know what I liked to read, what colour and I didn't know what I felt.*

This quotation borrowed from the interview with Brian shared many similarities with some of the thoughts put forward in the earlier sections. However Brian was not talking about material losses in his life. Brian had suffered significant losses but had managed to enter into his recovery in a relatively financially well off position.

Brian was referring to what he had lost as a person. He explained that he did not know what his interests were or if he even had any. Basic and fundamental things like having read a good book or showing a preference for certain things like his favourite colour were simply absent from his vocabulary of self-fulfilling and self-developing activities. These losses were

related to internal factors and were experienced in their full gravity once he had achieved abstinence. Once sober he had the clarity of mind to properly evaluate these things.

Brian also spoke extensively about his incapacity to describe and know what he was feeling. In response to this apparent deficit he explained how he had learned to mask his emotions as a means to cope with them. This problem had persisted several years into his recovery. He said:

> *People think I feel a lot because I outwardly look alright but the truth is I'm still emotionally screwed-up.*

Brian placed a lot of emphasis on not being able to understand his emotional life and related several other problems that he had to this. Many of the participants described having problems with being unable to understand and/or interpret clearly what they were feeling (Garland et al, 2011).

Substance-use appeared to be an attempt to control the way that they were feeling by inducing more positive emotions. When experiencing negative emotions they would medicate with their substance of choice to induce a more positive state. This way of coping later led to a reduced ability to tolerate any kind of emotional discomfort. Building on what has been discussed, Micheal offered some thoughts as to why he self-medicated excessively.

> *I think developmentally I was stunted, due to circumstance. Was I born with the disease? I don't know what it was, but I never developed at the same rate as other people, I've only been able to develop in post diagnosis in recovery.*

From a slightly different perspective, Micheal believed that a lot of his substance abuse was due to developmental deficits that resulted from his childhood. For him the substance use further exacerbated his other problems and, like with some of the other participants, caused him to realise with despondency that his substance use was not performing the function that he so desired. As a result of his underlying problems his development was arrested. Unlike certain of the other participants Micheal expressed an interest in the actual aetiology of his substance use rather than just examining the consequences that substance-use brought into his life (Ogden, 2007).

It was clear from his interview that Micheal needed to make attributions regarding the nature of his illness. For him in a general way, his addiction had inhibited his capacity to learn emotionally and develop in his life. Essentially he spoke about an arrested development in terms of his inability to tolerate negative feelings/emotions as both a cause for his substance use and a factor that maintained it (Garland et al, 2011).

These first two sub-sections aim to describe the holistic impact that substance-related disorders have had on the lives of these participants. Most of the participants reported an inhibited ability to deal with negative emotions as a result of their substance-use. Certain participants such as Micheal had spent a great deal of time trying to understand the nature of his illness, whereas most of the other participants were satisfied with simply knowing that whatever was wrong was serious enough to require ongoing assistance in varying forms. At this point no evidence regarding transformative or ameliorative processes had been presented.

4.1.4: That which was lost

This sub-section discusses a different collection of experiences. In contrast to the kinds of events that the participants described in the first sub-section, the events that are now presented can be understood as a different kind of event in the participants' lives, which represents complete defeat and/or a rock bottom (Chen, 2010; Cunningham et al, 1994). Before unpacking this construct the researcher felt that it was important to clarify what was being referred to so as to avoid what Szasz. (1957, as cited in Wurmser, 1977) refers to as 'panchestra'. That is, 'catch all' terms that are very broad. Terms such as this risk being imprecise because they potentially play into the researcher's desire to understand certain phenomena. Ultimately, they result in a loss of knowledge by over simplifying a highly complex matter (Wursmer, 1977).

Thus understanding these phenomena effectively and presenting the findings in this section in an accessible manner required that researcher pay close attention to the experiences put forward by the participants that they described as some of the motivating forces behind their recoveries.

The participants regularly referred to a "rock bottom" experience. The "rock bottom" experience was interpreted primarily in terms of the actual experiences put forward by the

participants. These events were characterised by a sudden, intense and painful emotional upheaval that ultimately resulted in a desire for positive changes in these individuals' lives (Narcotics Anonymous, 2001). The time line along which these events transpired was not uniform. The participants fell largely between the ages of 40 and 65 years old and so deriving an age-specific descriptor for when such an event was likely to take place was outside the scope of this study.

Rather, the researcher was more interested in what facilitated this significant event and the specific consequences an event like this might yield. It was important for the researcher to understand why this gravitatious event transpired at all. He felt that insight into this phenomenon began to illuminate certain of the questions that this study sought to answer.

The phenomenon of rock bottom is commonly associated with 12-step self-help fellowships. Although it is not uncommon to hear the term outside of the context of AA and NA settings, the term itself shares many substance-related connotations. Generally, the term is used to denote a turning point in the life of the substance abuser and is often referred to when alcoholics and addicts speak in their SHGs (Alcoholics Anonymous, 2001).

These events were characterised very often by significant loss that for the participants went much further than material losses in their lives. Now having reached a state of recovery the participants felt that the material damage and losses that they had suffered was reconcilable provided they continued to take the right steps in their lives. This section demonstrates several important dynamics. Specifically, it seeks to shed light on the distinctive quality and nature of events related to suffering in addiction.

Sara explained how her substance use had escalated to such a point that she felt there was nothing left to live for (Narcotics Anonymous, 2001). Her comments demonstrated an intense pre-occupation with substances but also an awareness regarding the impact that they had on her life. Virtually all of her ambitions and hopes seemed to be lost. She said:

> *I started using really hard drugs and by the time I was 32 I had literally completed obliterated my life.*

She did not refer to her life in material terms alone. She was referring to losses in her family relationships and her relationship with herself. Sara explained how she had arrived at a

point where she felt that there was nothing worth living for in her life. Thus she continued by saying," My life had stopped; I had stopped living my real life". Consequently she had lost the capacity to progress in anything and suffered a great sense of loss in her life. She explained that her substance use was the reason for this. There was no place for her anymore. She felt that the rest of the world had carried on with life in a normal fashion, while she had been left behind. Even in the depths of her addiction one of the things that caused her a lot of pain was the idea of what other people, including her past friends, might be doing or what they may be excelling with in their lives.

She did, however, explain that it was important for her not to hurt herself by fixating too much on the mistakes that she had made. What had caused her pain had become a great motivating force in her recovery. Sara still felt that she needed to make up for lost time. Sara had a conflicting awareness that she had done very well but she still felt that she had the potential to do a lot better. Even now she felt the need to do better. She actually attributed many of her present successes to her pathology. In some ways, although her addiction to substances is no longer there, the energy behind it still is and required a healthy repository to be put in.

Like the other participants, Sara described the various material losses she had suffered as a result of her substance-related problem. Later in her interview she went on to describe a place wherein she felt that she no longer had any other options available to her. Included in this were her accounts of the difficult conditions under which she attempted to stop using substances. This woman had absolutely nothing left of material value and sought help on a farm as she could not afford to go into formal treatment. According to Sara, she had reached a point of complete desolation. She said:

> *I was in a very bad space getting out of my using. I wasn't able to have counsellors, I didn't have guidance, and I literally went into a very hard environment where I had to live in a farm with nothing, no creature comforts, working and eating horrible food.*

Sara appeared to be sad at recalling the memory and seemed to put on a show of 'false bravado' seeing that the researcher was conscious of the way that she was feeling. However, Sara explained that this scenario was not actually the worst thing that she had undergone, and initially it seemed as though she may be trying to move onto another topic

that was less painful to speak about. However, the researcher realised he was mistaken when later Sara went onto to speak about what she felt the worst loss of her active-addiction-phase was. She said:

> *My kids were taken away from me, that's like the biggest worst thing. I haven't even spoken about that. They were taken away because of my using but my ex who was also using with me got them back. So that was a kind of crazy situation. His mother took them, told me to f-off and then she gave them back to him.*

Thus Sara's account evidences a blend of primary suffering and what is referred to in this section as secondary suffering. She had lost any sense of material wellbeing but had also completed alienated herself to the extent that she could not ask her family for help.

Finally her children were taken away from her as a direct result of her substance abuse. Similarly, Micheal described a process through which he had become completely self-destructive and how he had become a danger to himself and even to his own family. Although Michael's accounts share certain similarities with the extracts that have already been provided, there were some distinct features in what he said. As a consequence of his drug use Micheal had lost the right and privilege to care for his children. He explained:

> *I was married with children and I had a business and I had to relinquish all of that; I had to ultimately give my children up for adoption.*

Micheal found himself in a state of great emotional pain. Having made a decision to receive help for the problems that he was experiencing Micheal realised over time the damage that his addiction had caused in his life. The decision that he had made to give up his children to another family that was capable of taking care of them was done post active addiction and/or once he had already attempted recovery.

He attributed to his addiction, the tragic scenario that had unfolded. Amazingly, the decision to give his children up for adoption was only passed once he had achieved a relative state of health. He stated: "That was in their best interests". Micheal is now nine years abstinent from substances. He has recently remarried and runs a successful business.

It seemed as though Micheal felt that this event allowed him a greater perspective on his life. More specifically Micheal expressed that these events gave them access to something

that was previously unavailable (Krystal, 1977). Before then, Micheal explained that he did not care much for what other people thought about him or the way that he acted. As a consequence he damaged many personal relationships and lost out on many opportunities in his life. Then very suddenly, as if he was possessed by some external agency, he was granted great perspective on his life (Onken, Craig, Ridgway, Ralph & Cook, 2007).

The researcher was perplexed by this and felt that understanding this was a critical and valuable step. Returning to the transcripts, there seemed to be hints and clues scattered throughout the transcribed interviews. In discussing some of the practical challenges evident in treating people with substance-related disorders Khantzian & Treece. (1977) describe an "emotional walling off" that takes place in addicted individuals. This walling off is characterised by aggressive impulses and narcissistic rage (Daniel, 2012). These two constructs have been discussed in the previous sub-section. Khantzian and Treece. (1977) maintain that when addicted individuals are confronted with their rage and aggressive impulses in therapy they will relapse continually into substance abuse and a range of self-destructive activities.

To demonstrate, although Edgar and Garth's cross-addictions to gambling and work were attempts to stop-using; they also allowed the underlying problems that motivated the substance abuse in the first place to emerge and these problems consequently led them back to active substance abuse.

When interpreted in this context some of the participants' earlier comments regarding the cyclical nature of their attempts to stop substance abuse through cross-addiction and resulting relapses back to chronic and destructive substance abuse can be better understood. Krystal. (1977) discusses the previously mentioned emotional walling off specifically in terms of maternal object representations. Being unable to access the capacity to care for themselves the participants were in a sense doomed to inevitable relapse back to substances and other mal-adaptive coping strategies.

In contrast to what the first theme of primary suffering sought to illustrate; the experiences presented in this section were related to how the participants became abstinent. This was through some capacity or potential in these individuals that had become re-ignited, if in fact it had ever been kindled in the first place. What is meant here is that after experiencing

stress of a traumatic nature, the participants were temporarily able to search very deep within themselves and find the strength and will to discontinue their substance use.

The critical point here is that through profound loss the participants became able to take care of themselves. This newfound capacity was evidenced by many of them through the act of entering into formal treatment, as well as a range of other decisions that demonstrated integrity, self-respect and respect for significant others in their lives. Once this vital capacity was accessible to the participants progress in other vital areas could begin.

For example Micheal felt that it was necessary to allow his children to be taken care of by his ex-wife and her new partner. He was aware at some level that the problems that he faced were deep seated and that the consequences of certain of his past actions would take many years to resolve. Thus he understood that he needed time to take care of himself. Simultaneously it appeared that the great loss and pain that he had suffered allowed him enough perspective to later do what he felt was best for his children. Returning to Sara's interview, she disclosed what she felt one of the primary factors that motivated her to seek help was. She said:

> *My kids were taken away because of my using.*

Sara described this as "the biggest worst thing" that had happened during her active addiction. Sara has remained abstinent ever since this event and is now in her 15th year of recovery. She has become an icon within the circles of recovery wherein she interacts and helps to educate people in attempting to achieve abstinence through sponsorship and mentoring (Young, 2012). Bringing these memories to mind was difficult for Sara, however she expressed a commitment to the study in the interview explaining that it was important for her to continue, as, it helped to clarify and give her perspective on important events in her life.

Considering the context that the participants had come from in terms of their life experiences, their stories became admirable and awe inspiring. Previously, Hanna described the feelings of humiliation and anger that she had experienced in relation to the way that she behaved and was treated. She explained that she did not understand why she kept on experiencing the same negative scenario in her life. The repeated series of being institutionalised and legally restrained led her to many painful experiences (Fabricus et al,

2008). Some of the reasons as to why this mal-adaptive pattern continued as long it did have been explained.

Like the other participants mentioned in this section; the point wherein Hanna could finally begin to question the way in which she was living and whether she needed help was motivated by something different. She explained that after many years of painful consequences, she had come to realise that whatever her underlying needs were, the way that she was attempting to express this was both unhelpful and in fact very detrimental to her. She said:

> *I was just trying to justify and defend my position which was really untenable. I was self-destructive. I was completely committed to making my point be heard and not listening to everybody else.*

She had come to a point where she realised how her approach to problems in her life were no longer of any help to her. She saw how the anti-social nature of her substance use had left her completely alienated. There is an important distinction that can be drawn here. Micheal, Sara and Hanna's accounts in this section refer to different type/s of struggles that they indicated should be viewed as separate from other more peripheral consequences and experiences. The experience of losing children, divorces and becoming completely alienated by their substance use allowed them to ask the vital question, "is what I'm doing helping me?"

In primary suffering the substance-abuser experiences repeated negative emotions such as anxiety, depression and even hostility through the perpetual perception of loss, which took place at a material level. On the other hand secondary suffering can be equated with what many addicts describe as the process of 'hitting bottom' (Chen, 2010). Thus Garth's and Edgar's and even Hanna's accounts set out in the previous section fall into the category of primary suffering. Rather than motivate them to seek help the primary suffering led them to a greater dependence on external sources of coping as their real capacity to cope with life's demands diminished (Kaplan, 1977). Alternatively, the accounts offered in this section by these individuals can be understood in terms of secondary suffering and of hitting bottom (Chen, 2010).

Micheal had lost not just financially but had his children taken away from him. The same was true for Sara. Hanna was repeatedly institutionalised and at times had to be physically restrained. She suffered some physical abuse as a result of this. Through these events Hanna and Micheal and Sara were able to find the willingness and clarity to question what had been occurring in their lives. The examples that have been provided serve to demonstrate that the participants interpreted some events as painful enough for re-evaluating their lives, whereas others were seen only as problematic.

Drawing on several other examples it became clear that all that the participants described the psychological and emotional traumas that they went through during their active addictions as far outweighing any other negative material consequences. In the days before receiving help for their disorders many of them described a seemingly helpless state that was characterised by utter defeat and emotional turmoil. Garth said:

I think of that time as being like a time of like hopelessness.

From the experiences put forward by the participants, it seemed that a period of hopelessness and despair often preceded receiving help. Achieving abstinence was simply a logical starting point. Amazingly the participants spoke about these significant losses in a positive light, albeit, with an air of humility and reflection. All of the participants attributed their later success and recovery to these great life struggles. Arthur described a state of complete emotional turmoil where he had begun to lose his sense of reality. He said:

I basically lost my marbles; I had like severe panic attacks.

Arthur described his condition in the days before entering into a treatment programme as being delusional. His symptoms were psychotic in nature. Many psychoanalytic practitioners regard the diagnosis of different psychotic disorders as being the expression of different levels of psychotic functioning. For example, schizoid, schitzotypal and avoidant personality disorders are viewed by some as non psychotic versions of the schizoid personality type (McWilliams, 1994). Psychotic disorders have been understood in terms of both the familial approach which emphasises the traits evidenced in the non-psychotic relatives of schizophrenics; and the clinical approach which focuses on patients who appear to demonstrate the fundamental symptoms of schizophrenia without the psychotic symptoms (Jordaan, 2009). Arthur explained that one of the greatest gifts that he had received in his

life after addiction or in his recovery, was the restoration of his sanity. Throughout his life Arthur had suffered from psychological problems that appeared to be psychotic in nature. At time he feared that he would lose his mind. Arthur explained:

> *Like sanity where I used to get myself into this existential angst of um like the meaning of life and uh and I'd like flip out badly and and ya like, like in my extreme I thought I caused the tsunami you know that's how fucked I was.*

Arthur explained how he had begun to deteriorate mentally and he described the way in which he eventually believed that he was connected to natural disasters happening in other places in the world. In this instance it was Mozambique. He said:

> *It felt like God was there; it happened to be Mozambique and the Tsunami was happening and everyone was talking about the tsunami. So in Mozambique they were worried the wave was going to come there so I had this big thing that because I had crossed the line, the tsunamis happened.*

Arthur was drawing a parallel between his internal life and a real natural disaster that was taking place in a geographically far removed area and relating it to his internal experience. Thus there was a fearful and paranoid element that was present in his account. He felt that because he had crossed the line in terms of his drug use. For example, he used substances that he promised himself he would never use, and he felt that he was somehow being punished for his actions.

Psychoanalytically orientated practitioners acknowledge that people with psychosis have both intact aspects of their minds and other aspects that have been taken over by the psychotic process (Turkington, Martindale & Bloch-Thorsen, 2005). Therefore in psychodynamic models psychotic manifestations of the mind are viewed as being part of an active process that is both in a relationship and a conflict with non-psychotic aspects of the mind (Turkington et al, 2005).

In individuals who have psychotic disturbances, the psychotic part of the personality is more dominant than the non-psychotic part and is distinguished by its' reliance on projective identification. In terms of affect, psychotic individuals are especially intolerant of depressive feelings such as guilt or sorrow and throughout the process of therapy, will project these

feelings onto the analyst (Terry, 2003). This psychotic part of the personality is also intolerant of frustration and attacks thinking arrived at by work of the non-psychotic part (Lucas, 2003). The psychotic part of the personality attacks thinking by fragmenting the parts of the mind that are concerned with both the registration and differentiation of internal and external reality. Thus Steiner. (1993) aptly argues that one of the major threats to the hegemony of psychotic personality styles comes from the patients' own sanity.

Arthurs' sense that he had somehow caused the Tsunami in Mozambique and that the Tsunami was a punishment for his substance use can be understood in terms of Bions' notion of bizarre objects in psychosis. Bion. (1956) explains that the psychotic individual attempts to destroy his perceptual functions by splintering them into minute particles, and projecting these particles into external objects, which then become bizarre objects. These parts are expelled parts of the ego and are independent and uncontrolled and they continue to exercise their functions in a way that serves to increase their number and antagonism to the very psyche that ejected them (Bion, 1957).

Segals'. (1956, as cited in Terry, 2003) notion of symbolic equation in which the symbol is concretely equated with the object is helpful in understanding Bions' concept of bizarre objects. Basically, each particle which has been ejected by the psyche is felt to consist of a real object that is encapsulated in a piece of the personality that has engulfed it (Bion, 1957). The nature of the particle will depend partly on the character of the real object (Bion, 1957). For example, if a psychotic individual projects a visual function onto a computer, then it may be experienced by the psychotic person as watching him or her.

In the case of Arthur, he had projected his emotional state and function, which was one of guilt, due his substance abuse, onto a natural disaster that was taking place in an area that was far removed.

4.1.5: Making a decision

In summarizing what has been discussed so far; it was clear that certain of the negative consequences that the participants had suffered were not meaningless. By employing Chens (2010) framework of primary and secondary suffering the researcher was able to contextualise certain of the problems that the participants were faced with. To re-iterate Chens' (2010) framework, this author argued that secondary suffering becomes a key

motivator for treatment. Motivation for treatment is in turn a key predictor of treatment outcome (DiClemente et al, 2004). Thus a certain type of suffering that moved beyond material losses was according the participants, an essential element in the vehicle of change that allowed the participants to begin making significant changes in their lives. This suffering also enabled the participants to begin questioning why they needed to use substances so much.

It has been suggested that secondary suffering becomes a motivator for seeking help and/or treatment for these disorders (Chen, 2010). In lay terms, secondary suffering is understood as the individual 'hitting bottom'. The notion of 'hitting bottom' was variously understood by the participants. In the context of this study and based on what the participants said in their interviews, it was generally understood in terms of being completely defeated by their substance abuse.

This defeat in and of itself was insufficient, though, and needed to be accompanied by a shift in perspective. This shift in perspective was characterised by a willingness to receive help and a profound re-evaluation of their lifestyles (Johnson, 1993). Thus, a certain type of suffering that moved beyond material losses was an essential element in the addiction process. It allowed the participants to begin making significant changes in their lives.

However, the researcher still felt that the picture presented so far was incomplete; particularly in terms of the period preceding when the participants finally became abstinent. The researcher was intent on finding evidence that would illuminate this 'shift' in perspective. The notion of 'hitting bottom' is a concept that has been understood differently by different authors and theorists. In the context of this study and based on what the participants said in their interviews, hitting bottom can be understood in terms of being "so defeated by ones addiction that one is willing to be dependent again" (Johnson,1993,p.33).

Returning to the interviews, the participants explained that these events took place along a timeline. However, the actual data collected suggests that these critical points were unique to each individual. Material losses stood at the periphery of what was taking place in their lives. Material losses were a symptom of deeper underlying problems. They were not the primary problem. As things progressed many of the participants described increasingly severe losses in their lives. There was a tendency to separate material losses from losses

and breakdowns within their families and other significant personal relationships. It was suggested in the previous section that these losses led them to a point where they became able to re-evaluate their lives and take positive action. Previously the ability to take care of themselves was not present in their lives (Krystal, 1977).

One aspect of the participants active addiction phase manifested itself in the participants' inability to take care of themselves (Khantzian & Mack, 1983). This was demonstrated in the way that their professional careers began to deteriorate as well as the various health and social problems that they acquired over time. This period opened up a space of reflection and deciding to become abstinent appeared to be an intuitive step in approaching these underlying difficulties.

The researcher still felt that there was much to be discussed regarding what had actually transpired. Personal loss in its various forms seemed to be an insufficient explanation. All of the participants described a long history of substance abuse. The participants had placed substance-use before their responsibilities to their family and personal relationships as well as their professional careers. Some of them claimed that they had used substances in an 'addictive manner' from as early as age 11. Comparatively speaking, the participants had longer histories of drug abuse than they did of living relatively normal lives without the use of mind-altering substances. Thus before becoming abstinent they actually knew nothing else but substance abuse. They did not believe that there was another way to live. Even though in the earlier phases of their addiction they believed that they could control their substance use, they had ultimately arrived at points where they believed that they could not (Alcoholics Anonymous, 2001). For example Garth Said:

> *The only thing that I would have like to have changed if I could go back is that I wish that I had known that this was possible earlier in my life, I wish I had known that it was possible to live clean and that there was a way.*

Garth explained that he actually didn't believe that there was another way to live. He could not conceive of a life without substances. He attributed this assumption to the way that he experienced himself in the years that he was still using substances and also to his perception of the world. Like certain of the other participants, Garth felt that his beliefs about himself and the world around him were defective and actually perpetuated his substance use for

many years (D'Silva & Aminabhavi, 2013). For the participants, substances were considered the norm. Sara stated:

> *I started drinking when I was eleven so I can say that everything started going downhill from there.*

It seemed as though the participants had used substances and/or some form of escape for as long as they could remember. They knew little else. From a young age it was evident that many of the participants had employed a wide range of maladaptive or defective measures of coping. Then very suddenly there was a significant jump or alteration in the way that the participants lived. They were seemingly able to persist in a course of action that they were unable to take in the past. Their lives were infused by a sense of purpose and an increase in vitality and perspective (DiClemente, Schlundt & Gemmell, 2004).

Furthermore the sense of purpose was permanent. This was not to say that these participants suffered no relapses back to substances. One of these participants openly spoke about a relapse experience that she had had. It was as if a significant shift in trajectory from a process of self-destruction towards a steady desire for personal growth and healing had transpired.

Initially, the researcher felt that the fact that not all of the participants managed to become completely abstinent immediately detracted from the possibility that the same process was underway in the participants' lives. However, after a closer inspection, even Kayla's description of her relapse seemed to further clarify the findings that had already been put forward. It also brought to light some new insights. Her relapse did in fact serve to re-clarify what this individual already had begun to believe about her addiction. Kayla explained:

> *I only relapsed once; I relapsed on my hundredth day.*

Kayla said that she had still carried some level of ambivalence regarding her substance-use. She did not feel comfortable with the type of clinical supplements that the rehabilitation centre that she eventually attended utilised. This lady was desperate to stop using substances but still had certain reservations. Thus she was able to abstain for a while. While understanding at some level that it was the best decision for her, completely stopping her substance-use also made her aware of the fact that she wasn't just giving up substances, she

was giving up a lifestyle as well. Realising that her drug use was about much more than simply feeling good, she was consumed by fear, and returned to substance use (Glover, 1931, as cited in Krystal, 1977).

As compared to many of the other participants Kayla did not have any substitute for her substance-use. As has already been discussed; the sample of participants that were used for this study were chosen from a range of 12-step self-help groups. As such, many of these individuals attended 12-step rehabilitation centres, which encouraged attending the 12-step meetings of AA and NA. Therefore, if they so wished, they initially had something to replace their substance use with (Dodes, 1990).

Kayla, however, did not immediately accept this framework but had no other forms of emotional support in her life during that specific period. Thus in Kayla's case the idealised substance was not replaced as it was by many of the other participants with an idealised self-help group (Dodes, 1990). Kayla felt ambivalent about her relationship with this self-help group and the potential usefulness that it could have in her life. Thus there was a failure to replace her addiction with a healthier object of focus in the short term. Furthermore, Kayla felt uncomfortable with the structure and format offered by these self-help groups. She explained:

> *NA was just not my scene, that whole you know, the group thing and the whole like American vibe is just not my scene.*

She felt uncomfortable with sharing her feelings and what she was going through in a group format with people that she didn't know. She associated the format that is used in AA and N.A. with a stereotypical American ideal that she felt uncomfortable with (Tonigan, Connors & Miller, 1998). Because the substance represented something so profound, without something to replace it with, such as a therapist or significant other idealised object, her return to substances was inevitable. Thus Kayla could not immediately assimilate the 12-step framework into her life. However after suffering a relapse she felt that she needed to remain abstinent as her physical health was under threat. Thus the mechanism that the other participants seemed to possess was absent in this woman. She said:

So a hundred days down the line I was hating myself more than I could bear; the sight of me, the look, the sound of me, it was like this is it for me ,it was like that's it !!!.

Kayla's accounts make clear a very important idea that the first two sections sought to demonstrate. Even in the midst of great suffering, without coming into a transitional space, ones decision to remain abstinent cannot last (Alcoholics Anonymous, 2001). Something more is required. This was evidenced by the aforementioned ambivalence that seemed to play a central role in the participants not receiving help sooner. Kayla did however, explain that her relapse was informative to the extent that it reminded her that to use substances was to die and reaffirmed her decision to remain abstinent (Laudet & Stanick, 2010). Her view was consistent with specifically the NA philosophy that there can be only three potential outcomes to untreated addiction. These outcomes include jails, institutions and death (Narcotics Anonymous, 2001). The researcher felt that including an experience of someone that had relapsed was informative as it speaks to a non-specific factor in relation to what is un/helpful to the recovering individual and also to personal needs where recovery and treatment is concerned. Kayla said:

I went on a bender for about two or three days and luckily I made it out you know but after that I realised it's actually a very very clear choice, do I want to die or do I actually want to give this thing a go.

The threat posed to this woman was more than merely physical. It was existential. Thus her relapse had a strategic quality in the sense that it brought her closer to the realisation that when she used substances, her options were, to say the least, 'limited' (Galanter, Hayden, Castaneda & Franco, 2005). Her 'rock bottom' experience was simply an affirmation that reinforced her desire to recover. She said:

So I was lucky that that was my rock bottom; that was like very clear cut.

According to Kayla, after her relapse she no longer had any reservations regarding her substance use and took every action available to her in order to get well. These observations suggest that feeling certain about wanting to stop using substances and being willing to whatever it takes to recover are essential elements in the recovery process(Alcoholics Anonymous,2001).

Kayla considered this a pre-requisite for her recovery. It signified to her a new beginning and a second chance. Kayla did not believe that recovery was possible without surrender. Previously she had tried to 'will' herself to stop using substances and the result was unfavourable. The difference between her first and second attempt to become abstinent can be located in her willingness to recover (Medina, 2013; Tiebout, 1957). It also demonstrated that coercion was not helpful to her (White, 2007). She could not be forced to remain abstinent. At a peripheral level, Kayla understood that her substance use was problematic but internally she had not considered what substance use represented to her. Thus she was not able to remain entirely abstinent. However once she had become willing to recover there was less resulting tension as internally she had processed the far-reaching implications of her substance abuse.

Through sometimes severe personal loss associated with personal relationships and break downs in mental functioning, many of the participants found the motivation to seek help for their problems. This fact is relevant because it pertains to the long-asked question of what motivates people with substance-related disorders to seek help. It was saddening for the researcher to observe that the accounts provided so far suggested that people with substance-related disorders seek help only when their lives become unbearable (Chen, 2010).

Through a detailed analysis of these accounts it became clear that in and of itself, substance use did not account for the vast range of consequences that the participants had experienced. It also did not make sense to explain all of these consequences as simply a manifestation of an addiction syndrome. It was not appropriate because it did not comprehensively account for the variance in their individual experiences. For example, they did not all suffer the same problems in their professional careers nor were the disturbances that occurred in the family unit uniform. That is to say that there were considerable differences that had to be taken into account. What the initial sub-sections that are concerned with the meaning of suffering serve to emphasise; is that the pattern of self-destruction increased as their dependence on substances increased (McLellan, 1986). Having written this, one of the common elements that arose through analysing the interview transcripts was that many of the participants were in fact aware, at some level,

that their substance use was causing both them and the people around them harm long before they became abstinent (APA, 2000). For example, Gideon said:

> *I knew I was an addict long before I came into recovery.*

There was therefore a certain level of awareness surrounding his substance use. The question therefore is simple. If a person has a substance-related disorder and is aware that it is a problem then why doesn't that individual seek help sooner as opposed to going through years of seemingly masochist chaos and suffering? Drawing on the context of Gideon's interview it would seem that at a basic level, he initially found his drug use pleasurable. He stated:

> *It was manageable and it was good, and then things changed.*

The notion that drug use is pleasurable is not uncommon and can be found in much of the substance-related literature (Volkow & Baler, 2014; Wise & Koob, 2014). The pleasure that Gideon derived from his addiction was not derived solely on the ingestion of psychoactive substances but also from the lifestyle surrounding his drug use. He continued:

> *My life was so involved in the drug world; getting, using, selling, and doing I had a very hectic schedule.*

Gideons' experiences and the level of pleasure that he derived from these activities were multivariably determined to the extent that his entire lifestyle was centred on a pre-occupation with substances in some form or another, as well as the various activities that surrounded his drug use (APA, 2000). A comparison between his comments here and the idea of going to work or a professional career can be drawn. This comparison denotes the disproportional pre-occupation placed on substances in his life. There was also the sense that he took pride in his occupation and felt a tangible level of responsibility to this occupation (Kim, Namkoong & Ku & Kim, 2008).

Kayla's comments helped the researcher to expand on comments that had been made regarding the participants absolute pre-occupation with substances. She maintained that besides the psychological effect that her drug of choice had on her; she had begun to equate the effect produced by the substances that she was using, with her real response to the environment. Thus, the ingestion of a substance allowed her to engage with her

environment on multiple levels. External cues gave her and supported her sense of self (Frosch & Milkman, 1977). She said:

> *This whole like passionate affair of the drug and the people you know, the nightlife and that craziness was something that was my identity.*

According to McWilliams. (1994) individuals who organise their self-esteem around external affirmations are referred to as narcissistic by psychodynamic theorists. The fact that Kayla required external cues to make herself feel better was indicative of a certain level of narcissism. However, a distinction can be drawn between those who are pathologically narcissistic and those individuals who have narcissistic elements in an otherwise normal personality (Garcia, 2003).Kayla never spoke about having a narcissistic personality disorder, however, many of the participants spoke about a continued need for external sources of gratification.

Gideon and Kayla's comments also brought to mind one of the central premises of this thesis. Individuals who become addicted to substances do so to self-medicate (Khantzian, 1985). Simply put this the self-medication hypothesis argues that the substance that an individual chooses to abuse is not a random phenomenon. Rather people who abuse substances do so because the short-term use of these substances helps them to combat emotional, relationship and behavioural problems (Khantzian, 1985). The participants referred to the substances that they used as their 'drug of choice'. This is often referred to as the 'drug of choice' phenomenon. So, an individual will eventually settle on a specific substance to fulfil a psychic need that is based on his/her personality type. For example Kayla said:

> *I think because my drug of choice was cocaine; that was the drug of choice which promoted the feelings of euphoria and just this deep love and connection to the universe, which was actually not real.*

As has already been discussed, attempting to define ,"addiction" is a difficult task. Defining addiction in terms of physical dependence alone is also not helpful because it does not account for the complex function that substance use performed in the participants lives'. For example, marijuana or dagga addiction was at one time not viewed as problematic, as it did not produce a physical dependence on the substance (Weider, 1977). Neither does

cocaine for that matter. Thus the focus that Kayla placed on her particular substance of abuse suggests a deeper more concealed need to use this specific substance (Mariani, Khantzian & Levin, 2014). The participants' comments regarding the extreme nature of their lifestyles are also consistent with the literature that has examined factors that either impede substance use or support it. This literature suggests that factors in the DSM-IV-TR framework that reflect psychopathology are associated with a greater risk for relapse (Charney, Zikos & Gill, 2010). In this respect, the concept of impulsivity speaks directly to some of their experiences with substances and the associated lifestyle (Dawe & Loxton, 2004; Dodes, 1996).

Kayla complained about chronic feelings of boredom and emptiness in her life. She became particularly aware of this in the period after she became abstinent or in her early recovery phase (Charney et al, 2010). In discussing some of the factors that were detrimental and or harmful to her recovery Kayla made some comments that were initially disregarded. Her comments did not seem to be consistent with much of the popular literature on the topic of recovery from substance-related disorders. Thus the researcher thought that it was unusual for someone who had gone through so much in her life to describe boredom as one of the greatest threats to her recovery. Kayla said:

> *I found it very hard being in a corporate job and so very boring long meetings used to drive me crazy but I couldn't leave. At one point I couldn't understand what they were talking about it was just very boring, that that for me was a real, I had to excuse myself and people would say like where you going you know. I had to go to the loo and just like calm down because those are things that would affect me just long boring, just droning on. I couldn't handle that like stupid things that normal people don't have a problem with ummmm it really bothered me so that's the, uhhhh harmful things.*

The other participants readily elaborated on textbook relapse triggers while Kayla referred to something as arbitrary as sitting in a meeting as one of the most dangerous threats to her recovery(Robles,Huang, Simpson & McMillan,2011). In relation to triggers that led to a desire to medicate with substances, Khantzian (1985) argues that the use of stimulants such as cocaine leads to increased feelings of assertiveness and self-esteem and also to the alleviation or termination of feelings such as boredom or emptiness. Even though Kayla was

sober, it seemed as though she had not yet developed her capacity to deal with situations that she experienced as uncomfortable.

This placed an interesting twist on the findings and led the researcher to re-evaluate some of what had been said by the participants. Although there were many reasons for Kayla's chronic substance-use, one of the primary motivating factors underlying her substance use was the need to rid herself or self-medicate against uncomfortable feelings, which in this instance appeared to centre on boredom and emptiness (Mariani, Khantzian & Levin, 2014). This finding contextualised some of her earlier remarks and was consistent with the descriptions that she provided about her lifestyle while she was using substances. Of particular importance was her excessive need for stimulation in her life. Kayla described a scenario where her drug dealer asked her to collect a vase full of heroin from Cairo. Kayla described the excitement that she experienced upon receiving the offer and spent a lot of time deliberating about whether she should do it. She said:

> *Go and fetch a vase from Cairo and bring it back with stuff in it. You know that type of thing and I had zero cash. And nobody would know. He said he'd pay me fifty grand. 50!!!! Like that was a lot of money ten years ago. Like fetch a vase in Cairo and bring it back and I really I was stupid enough to consider it.*

Kayla did not actually make the trip to Cairo to collect the vase full of drugs and transport it back to South Africa. Her account here can be compared to certain of the participant' earlier accounts in which they described scenarios relating to financial losses in their lives. Kayla's comments, however, also speak to the fundamental compulsiveness related to her disorder (Dodes, 1996). However, beyond this, their reasons for using substances in such a desperate and destructive manner were difficult to determine. It was interesting to note that none of the participants attributed difficulties in their recoveries to the phenomenon of craving. This is strange because the amassed evidence supports the idea that many addicts return to drug use as a result of craving (Skinner & Aubin, 2010). What is of even greater interest is that important elements of the AA doctrine posit that craving is the result of a physical allergy to alcohol (Alcoholics Anonymous, 2001).According the Big Book of Alcoholics Anonymous. (2001, p.xxviii), craving refers to the following:

> *The action of alcohol on these chronic alcoholics is the manifestation of an allergy; that the phenomenon of craving is limited to this class and never occurs in the average or temperate drinker. These allergic types can never use alcohol safely in any form at all; and once having formed the habit and found they cannot break it, once having lost their self confidence , their reliance upon things human, their problems pile up on them and become astonishingly difficult to solve.*

However, rather than attribute her substance abuse and subsequent relapse back to substances as being the result of craving, Kayla attributed her relapse to a negative self-perception that she carried in which she described powerful feelings of self-hatred. It appeared that being present in an environment in which the general perception was that people wanted to recover exacerbated these feelings. However, Kayla had not yet made a decision to utilise this framework for recovery and so in some ways this created a conflict. The conflict was orientated around knowing that there was a potential solution to a life-threatening problem while simultaneously feeling ambivalent about following through with this course of action.

In conclusion of this subsection and chapter, the findings presented pertain to several critical dynamics in substance-related disorders. Included in this section was a focus on some of the intrapsychic dynamics associated with severe substance-use such as denial and ambivalence. The difference between primary and secondary suffering was also discussed with specific emphasis being placed on the notion of secondary suffering and/or “rock bottom”, and these participants being able temporarily to take care of themselves in a meaningful way. This ability was expressed by them actively seeking help for their substance related problem and attending support groups. The concept of narcissism was introduced to the in this section. This concept will be discussed in greater depth further on in this study. Finally, it was argued that the role that a specific substance played should not be taken for granted. By this it is meant that often the substance that is later settled on, performs a very specific role. In this instance Kayla’s cocaine addiction and the accompanying lifestyle were argued to be consistent. This is an idea that will be revisited at several points throughout the forthcoming chapters.

4.2: Part 2: A Shift in Trajectory: The Factors that Facilitate Recovery

4.2.1: The acknowledgement of the substance-related disorder as a problem

This section is titled, 'a shift in trajectory' to denote events, processes, thoughts and ideas concerned with the period after the participants achieved remission from their substance-related disorder. These first few sub-sections engage with factors that are primarily concerned with the transitory period preceding longer term recovery or the early recovery period (Charney et al, 2010). The first area of focus is the first years of abstinence. The discussion then turns towards those factors that are relevant to and facilitate longer-term recovery.

Much has been discussed in relation to the experiences that these participants went through before they received help. The previous sections clearly demonstrate the destructive potential of untreated substance-related disorders. It was frightening to observe that suffering alone is insufficient to resolve the substance-related disorder. Something more is required. Through more profound losses including the loss of/and breakdowns in relationships some of the participant's came to the realisation that their substance-use was inhibiting them from dealing with certain underlying problems and progressing in their lives. Secondary suffering or hitting bottom enabled these individuals to actively question and make the first attempts to deal with their substance use problems (Cunningham et al, 1994). They understood the negative impact that substance abuse had in their lives and became willing to seek help.

In summarising what has been discussed so far, a substance-related disorder can cause significant distress to individuals who become addicted to substances. The researcher utilised examples related to material losses to demonstrate a type of suffering that was insufficient to significantly alter the substance-related disorder and the lifestyle surrounding the substance abuse. Primary suffering did, however, in certain instances cause some brief reflections into the role and function that substance use in its various forms played in the lives of the participants. It was argued that ambivalence and denial play central roles in perpetuating the substance-related disorder (Blaine & Julius, 1977).

Those participants who were able to replace their substance-abuse problem with something that was seen as being able to fulfil vital needs at multiple levels were able to transition into a life defined by complete abstinence much more easily than those who remained ambivalent and held on to certain reservations regarding their substance-use. In this instance the various 12-step fellowships that the participants attended were considered to be one of these substitutes (Dodes, 1990). Kayla's experiences set out in the previous section demonstrated this dynamic concisely.

It became clear that one of the factors that presented as an obstacle to achieving abstinence was the belief and sometimes the fear that there was simply no alternative to a life of complete dependence on substances and other maladaptive aids. To re-iterate, the process of secondary suffering simply created a potential wherein the individual was faced with a choice to either seek help in some form or to continue abusing substances. Thus, it was still open ended in terms of whether they would stop their substance use or not. Knowing that there was a problem was not the solution in and of itself.

Example

The following extract illustrates a point that the researcher felt was responsible for certain of the participants being able to immediately achieve abstinence while certain of them were not. Martha explained that she had received a formal diagnosis of having a substance-related disorder when she was eventually admitted into a treatment centre. She also explained that she had been aware that she had a problem long before ever being admitted into a formal treatment centre. Her admission of a problem was therefore private and shallow to the extent that she never truly sought to understand the nature of her problems. Thus, knowing that she had a problem was by itself insufficient to sustain her attempts at discontinuing her substance abuse. This knowledge did, however, motivate her later on to seek help and admit herself into a formal treatment centre. She said:

> *Before I received that diagnosis I was aware that I was an addict, I was aware that I had some sort problem; I always knew that I had some sort of problem.*

Martha had known for many years that there was an underlying problem. She also knew that her pre-occupation with substance use was somehow an expression of this problem (Wurmser, 1974). However, this awareness alone was not sufficient to completely stop her

substance use and so she continued to abuse substances for many years. Like Kayla, she had nothing to substitute her addiction for. Without attempting to understand the nature of her problems she had no tangible starting point. It has been briefly suggested that one of the possible reasons for this was that she did not believe that there was any sustainable alternative to active substance abuse.

For Martha and other participants such as Kayla the effect produced by substances was so insidious and had become so natural to them that compromising their substance-related behaviour in any way was simply too terrifying for them to even consider on a long-term basis. Martha explained that during this period of her life the pay-off of using substances was too great to completely stop.

The next extract illustrates an integral shift for Martha. Before this point she was unable to control her substance use. She had admitted to herself before that she had a problem but did not feel comfortable with sharing this with anyone else. It was only after attending formal treatment that Martha was able to trust something enough to give it a chance. After attending formal rehabilitation Martha felt willing to explore other forms of emotional and social support including the 12-step fellowship. She said:

> *Once I realised that there was another way for me to live a life where I didn't have to take drugs and where I could find myself and I could become a better person and I could become diligent and not be completely insecure all the time and where I could be happy with myself and have some kind of future like some sort of involvement in life and I realised that the programme could supply me with all that then I realised that I'm on to a good thing.*

The researcher felt that this fairly long extract contained so much that was in fact relevant to some of the ideas that have been forward so far that he chose not to break it up into smaller segments. Through describing what she believed could be attained through a life of sobriety and the appropriate support systems, Martha was inadvertently referring to some of the things that she had used substances to escape from and deal with.

These things included a life of abstinence, increased self knowledge, a life that was not controlled by substances and that forced her to participate in a wide range of behaviours that made her view herself as 'bad', more self-acceptance and a chance to be a part of the

world around her instead of being completely alienated by her disorder. These were some of the things that Martha felt were missing in her life. Martha's comments here demonstrate a profound need for security and guidance as well as for ongoing positive growth in her life (Galanter et al, 2005).

Before reaching this point, Martha never felt confident enough that anything could actually help her. Martha needed certainty before she felt safe enough to commit to anything. As has already been discussed Martha wanted a great many things but felt incapable of achieving them. Her introduction to the 12-step program gave her hope and the belief that her needs would somehow be met. Furthermore she believed that by achieving abstinence she would be in a better position to start dealing with some of her underlying problems (Chavis & McMillan, 1986). Formal treatment and her introduction to the 12-step fellowship gave her the courage that she needed to make a start. She did not need to understand the implications of following this course of action completely. All she needed to know was that it would somehow lead to improvements in her life.

Martha's statements are demonstrative of a scenario in which a shift in trajectory has been achieved. It seemed that the essential ingredient here was the belief that there was an alternative. Thus things such as denial and ambivalence where substance use was concerned was made possible through the individual misunderstanding and/or taking for granted how great the individuals need for self-medication was in the first place (Khantzian, 1985). Not being able to ask for help was deeply related to fears of what life would be like without the use of substances in some form. These fears were intolerable. Not being able to ask for guidance on the matter also appeared to be related to the belief that no one could help her and that she was completely alone in dealing with her problems.

It seemed that a true acknowledgement of the problem became a motivator for change. Once acknowledging the gravity of the problem these individuals were temporarily able to exercise parts of themselves in the form of modified attitudes and behaviour such as an improvement in self-care. These functions were previously unavailable to them. Secondary suffering offered Martha a potential through which the capacity to reflect on and take steps towards dealing with her problems was made possible.

Section 4.2.1 now returns to that space in which intervention and recovery becomes possible and pays special attention to the way in which these individuals convert their willingness to get well into to something more concrete. Turning now to the first step in facilitating a shift from pathological substance use to the long and often difficult journey towards health, the researcher put forward some of the ideas that were considered essential by the participants.

It was apparent from the interview process that conceding that the substance-related disorder was a problem was a significant first step in becoming abstinent. Although the participants' views around how to do this or to whom one should confess this truth varied from participant to participant; it was apparent that this concession was a necessary pre-requisite for arresting the substance-related disorder (Ralph, 2007). It took place at one of two levels: (1) a personal acknowledgement to the self that the behaviour had become unsustainable and was essentially failing in fulfilling the needs that the substance was being used to support, and (2) a public confession usually at the treatment level (but not always) in the company of others.

The admission that one had a problem appeared to an essential component for the participants in taking the first steps towards becoming abstinent. Admitting that they had a problem was like *'*pulling their heads out of the sand'. In and of itself these confessions did not cure the substance-related problem. However, admitting to the impact that their substance use had had on their lives did provide them with a point at which to begin their journeys' of recovery. Previously, the participants had tried to control their substance use through a variety of strategies. Often these strategies were misguided and maladaptive. These included cross-addicting to other things in their lives that could temporarily relieve them from the intolerable emotional states that they used to experience and to quell their obsessive preoccupation with substance use and the lifestyle surrounding their substance use.

Going directly to the individual points where the participants managed to achieve remission, Garth explained that one of the most difficult aspects related to abstaining from substances was admitting that he had a problem. He described the incredible relief that he felt at finally being able to speak about his problem openly. Over time he realised how painful having to keep the problem to himself for so long had been. He said:

Suddenly this thing that had been part of my life for like 20 years, there was something that I could do about it , just by acknowledging that it was a problem.

Acknowledging the true nature of his addiction allowed Garth to take steps to deal with the disorder. It gave that which was nebulous, insidious and hidden a tangible quality that he could begin to approach. Having made attributions regarding his problems that were in fact false deterred him from being able to objectively assess where his problems were coming from. In spite of the tremendous consequences that he was faced with as a result of his substance abuse the true nature of his problems remained hidden. Realising that he had a problem and admitting this publicly was an important step for this man (Alcoholics Anonymous, 2001). This enabled a subtle shift that that would later become a powerful foundation of a successful, healthy and fulfilled life. He continued:

Just being able to do that meant that I was able to take steps to change the way I lived.

In this particular instance, Garth was talking about how important it was for him to acknowledge that he had a problem in the company of others. He spoke about the sense of hope that it gave him as well as a sense of freedom and relief that he experienced through finally being able to share his problem. There was the sense that he had managed to 'let go' of something that weighed very heavily on him (Johnson, 1993). Previously he had refused to ever speak about or acknowledge this problem to another person. Admitting that his substance use had become untenable allowed this man to take the first essential steps towards achieving abstinence.

Garth repeatedly emphasised the importance of doing this in a public scenario. This 'letting go' represented a similar shift to one previously discussed. It was more specific now. It represented a shift from a dependence on substances to a dependence on other people. Doing this consistently in the company of other people allowed for a gradual relinquishment of the substance-related disorder (Johnson, 1993). This confession provided Garth with a stopping point that he chose to act on and take reponsibility for. It gave him a second chance to negotiate some of his previous challenges in a way that was sustainable.

Hanna presented a different yet complimentary scenario. She explained that through years of pain and suffering she had reached a point where she realised that alcohol was not her

problem. There was a fundamental paradox here. On the on hand, Hanna's previous lifestyle had been characterised by denial in terms of her substance use as demonstrated by her repeated admissions into psychiatric institutions and holding cells. In spite of these events she never really believed that she had a problem.

At the same time, as long as she believed that becoming well was simply a matter of regulating her substance use or alcohol consumption the 'real' problem could not be dealt with. Hanna was only able to achieve abstinence once she had looked inside of herself rather than at external expressions of her disorder/s. To demonstrate she said:

> *I saw that the problem was me; when I saw that my life turned around and I started dealing with me rather than with being the victim.*

The researcher interpreted what Hanna had put forward as a confession of sorts. She explained that she had stopped blaming the world around her for her troubles. Her attributions regarding the nature of her troubles were now located within her. A significant shift from seeing the world around her and various external circumstances as 'bad', scary, out to get her and as the source of her problems; to seeing that the way that she had behaved and her chaotic internal life as responsible for what she had experienced. Hanna said much to illustrate this point. It had become a prerequisite for her that before judging to any situation, she must first search herself for the cause of whatever she was going through.

Finally, Gideon explained that knowing that he had a problem was insufficient to solve the substance-related problem. He said: "I knew I was an addict long before I came into recovery". Gideon was aware for a long time that his substance-related disorder was having a negative impact in his life. Like Martha he continued using substances because he refused to acknowledge his problem publicly. He also felt that the payoff of using substances was too great to completely relinquish his substance use altogether. Through the process of secondary suffering Gideon also arrived at a point where he had to find a way to deal with his problem. However he was unable to alter his situation because for a long time he was unable to publicly acknowledge his problem to either a therapist or in a group setting or otherwise. He also finally arrived at a point where he felt that he was able to make a decision about his substance use. Unfortunately it was only after many years of suffering. He said:

When I decided I was coming in (to treatment) I made the decision I was going to be clean and that was the motivational part of it.

Gideon felt that admitting that he had a problem alongside his decision to stay clean gave him a sense of motivation that allowed him to take the required steps towards building a new life (DiClemente et al, 2004). In a way Gideon was actually saying that he was no longer a using addict. For him, if he wasn't using substances he wouldn't crave or experience obsessions related to his substance use. What Gideon had in common with the rest of the participants, who all finally achieved a state of complete abstinence, was that he was certain about his decision to stay clean. He had no reservations because he had a clear picture of what he wanted in his life and of how the substance-abuse was affecting him.

In concluding this sub-section it was ascertained that a public acknowledgement of the substance-related disorder as a problem was integral in beginning the process of abstinence from substances. Essentially a public admission of the problem is the shift in trajectory that this chapter seeks to illuminate. It is also the first shift in trajectory as they are multiple shifts that will later be discussed. It appeared that a public concession of the problem allowed the participants to slowly relinquish their relationship with their substance of choice. The decision to publicly acknowledge their substance-related problem was also related to motivational factors involved in getting clean. A final point worth mentioning is that being certain that abstinence was the correct life decision for them made it easier to take the steps that followed. In conclusion acknowledging the substance-related problem acted as an essential first step in mastering their substance related disorder.

4.2.2: A laypersons definition of recovery: Surface level changes

In relation to the question of, "Tell me about your life now as compared to your life before your diagnosis" the participants shared much about their lives. They spoke about the way that they viewed their recoveries and they used examples that were drawn from their past experiences to demonstrate the depth and nature of the changes that had transpired in their lives.

Although the interview questions did not ask as much there seemed to be a natural inclination for the participants to want to define their recovery experiences. This section focuses primarily on the way that the participants interviewed in this study chose to define their recovery experiences. In a similar manner to chapter ones', 'the meaning of suffering in substance related disorders', wherein primary suffering and secondary are described separately; so the way in which the participants defined their recoveries was sub divided into two sub-sections, namely 'a lay persons definition of recovery' and the following sub-section of 'into the light'.

The researcher felt that discussing their varying definitions of recovery was helpful because it provided a framework for accessing the participants' worlds in terms of the way that they viewed, interpreted and constructed their illness and their recoveries. The assumptions that they had regarding how recovery functions, determined the measures that they utilised in order to maintain their health and develop as individuals. These assumptions provided the researcher with valuable insights that were relevant to the study.

It was unsurprising to find that many of the participants defined their recoveries in terms of the acquisition of material assets. The same way that the participants initially spoke about their earlier active-addiction phases in terms of the loss of material assets; so they initially discussed their recoveries in terms of material development. Thus a converse relationship can be drawn between the financial implications and losses of their active addiction phases and the financial developments that took place in their recoveries. They would often begin by describing the way that their lives had changed materially. For example, Kayla said:

> *I have gainful employment; I never thought I would ever have that.*

So low was her self-esteem entering into recovery that she did not believe, for a time, that she was capable of getting a job and remaining in that job. She described her work as 'gainful' suggesting that there was a pay-off or added benefit to the type of work that she did. There were now opportunities available to her in her work space that had simply not been available to her in the past. Her work meant more to her than just a cheque at the end of the month. Kayla spoke at length about how meaningful her work was to her. One of the reasons it meant so much to her was because she believed that it allowed her to give back in her life. She continued:

It allows me to give back, which is pretty much what I think recovery is.

Kayla actively sought her recovery ideal in her work. It was as if work itself was a secondary concern compared to what she actively sought in her life. Kayla had created a workspace wherein she could practice what she believed was fundamental to her recovery. This fundamental thing was something altruistic and reciprocal. It also provided a sense of congruence. Recovery for this lady was no-part time affair and it was important for her that she express these principles and values in other areas of her everyday life.

Kayla utilised a moral framework for understanding what needed to be done in her recovery (El- Guebaly, 2012). This moral framework could be viewed as a relic that Kayla had carried with her and that she had learnt from the type of rehabilitation that she underwent. Thus, Kayla defined her recovery in characterological terms (White, 2007).Although the participants all differed in the way that they defined their recoveries; notions of 'giving back' to the world in some way were plentiful. On a related note, Sara explained that her financial status had also changed positively since entering into recovery. She said:

Maybe it's a lot to do with materialistic stuff I have my own home, I don't owe anyone money, in fact I've realised I'm a really good saver, I've realised that I'm actually very responsible about money.

Sara openly acknowledged that she was defining major changes in her life in terms of material assets. As has already been discussed, Sara had lost virtually all of her material possessions during her active addiction. Thus it was natural to take pride in the material and financial advancements that she had made in her life. Beyond actually earning more money, Sara was able to handle her money responsibly and was no longer financially indebted to anyone. This suggested yet another improvement in her ability to take care of herself; a capacity that was previously non-existent as a result of her addiction and was to a large extent absent while she was in her earlier life.

However there was the sense of something else being communicated as well. There was an underlying message. Initially Sara appeared to have conviction about the path that she had taken in order to secure her recovery. She did not doubt that the changes that she had made were positive and that remaining abstinent from substances was the correct life path for her. However, while reflecting on the changes that had taken place in her life she

showed a certain degree of doubt as demonstrated by her pauses and apparent need to present to the researcher the progress that she had made as somehow acceptable.

It seemed as though she was still in doubt of the progress that she had made in her life. This was illustrated by her apparent need to impress upon the researcher that her progress was meaningful. It was as if her achievements, of which there were many, were presented as a gift to the researcher for his judgement. She constantly sought the researcher's affirmation as to whether the information that she was giving was acceptable or not.

Interestingly Sara is an individual who prides herself on being a hugely disciplined and persevering person. She is fiercely independent and someone who believes that she can overcome any odds. The researcher was surprised to see her become so self-conscious when she spoke about the many positive material advancements that she had made in her life. She continued:

> *Now I've written my fourth book, I'm publishing books I mean I could go on and on, I've really like kind of caught up with the person that I left behind.*

Sara described the massive expectations that she placed on herself. She felt a terrible sense of loss after stopping her substance use and had subsequently led a life based on achievement ever since then. Even after having publishing four books, Sara still felt the need to excel more in her life. It was clear that her Sara's recovery was firmly rooted in a sense of agency as expressed by her goal directed determination (Onken et al,2004).The researcher wondered whether there were similarities between her active addiction phase and her attempts to mend what was happening inside of her with substances, with her present need for achievement. This idea will be discussed in the forthcoming chapters. What was unfurling here was more complicated and will also be later discussed. What is relevant to this section is the way in which she defined her recovery. She explained a process of making the person that she used to be catch up on all the things that she had missed out on in her life. While other participants defined their recoveries in terms of disengaging with the thoughts attitudes and behaviours that once drove them, Sara's definition was related more to a retrieval of the person that she once was of (Ralph, 2007)

Most of the participant's took some time in their interviews to speak about the material advancements that they had made in their lives. It seemed that performing well

economically provided the participants with a sense of safety in their lives and acted as a source of pride and self-respect for them. It could thus be viewed as a barometer of sorts through which they unwittingly assessed their recoveries by. It was also indicative of internal changes that had transpired.

These included an improved capacity to care for themselves as evidenced by the economic structure and level of responsibility that they now possessed and generally a greater capacity to comfort themselves with healthier external aids. Edgar also took pride in the fact that he had re-created his life financially. He said:

> *I've got two houses which are fully paid for , two cars and probably about four and a half million in the bank in savings and investments compared to a debt I had sixteen years ago.*

There were many other examples in the interviews of how the participants had managed to recover financially and also to go on to develop much further than they had previously envisioned. The researcher wandered whether the participants' initially defined their recoveries in terms of material assets because it was simply a way to demonstrate that stopping their substance use had improved their lives and demonstrated the changes that had taken place in their lives or whether there was more to it. Although hugely positive these changes also appeared to be surface level changes. They were the consequences of living in a particular way rather than the primary goal of and for recovery.

What the accounts provided in this section demonstrate is how during the early recovery phase there is a great need for empowerment. According to Rappaport (1987) the concept of empowerment suggests both individual determination over one's life and democratic participation in the life of one's community. This empowerment was demonstrated by their various work and material acquisitions, as well as their involvement in the various 12-step fellowships that they attended. Empowerment conveys both a psychological sense of personal control or influence and a concern with actual social influence, political power and legal rights. Similarly, Swift and Levin (1987, as cited in Vlaenderen & Neves, 2004) believe that empowerment refers simultaneously to the development of a certain state of mind (feeling powerful, competent, worthy of esteem) and to the modification of structural

conditions in order to reallocate power. Therefore empowerment refers to a subjective experience and objective reality and is thus both a psychological and social process.

Another idea that has been neglected in the substance-abuse fields regarding recovery is that of life satisfaction. Although this area has been neglected, as is clear from the participants' accounts, it appears to play a significant role in the recovery process. The definitions provided in this section lend themselves to the notion that recovery from substance abuse is a voluntary lifestyle of which abstinence is just one factor.

It seemed that going back into the world and taking on new challenges as expressed by the participants' various successes in the workspace acted as a healthy counterpart to the feelings of grief and loss that they had experienced during their active addictions. There conceptions of recovery also appeared to be grounded in the belief that recovery is in large part associated with healing through self-sufficiency (Onken et al, 2007).

The findings put forward in this chapter reveal the need for a sense of achievement in the participants' lives. These findings are consistent with many popular bodies of recovery-orientated literature that emphasise that recovery is rooted in a sense of agency (Onken et al, 2007). This sense of agency translates to several goal directed behaviours, in this instance the attainment of material well being. This sub-section illustrates one of the single most distinctive features of approaches to empowerment in that empowerment is conceptualised as being transformative as opposed to simply ameliorative. In a very broad sense the accounts put forward emphasise a multiplicity of solutions in many diverse settings, including the work place, as opposed to single solutions that in this instance would refer to simply substance cessation (Rappaport, 1987). Finally, all of the participants were willing to seek help for their substance-related disorders. This finding is in keeping with the notion that recovery from a substance-related disorder must be volitional (White, 2007).

4.2.3: A clean start

Most of what has been discussed up until this point has been orientated around events that hold significant weight. These events can also be argued to be the outcome and culmination of much smaller events that are easy to overlook. These 'smaller' things were primarily orientated around a set of behaviours and routines that the participants felt were necessary on a daily basis and they constituted the foundations on which their daily recoveries were

based. These behaviours varied greatly but in their essence held certain similarities. These similarities clustered around a need for structure in their lives on a daily basis. For example Arthur said:

> *My family, I make them all breakfast, and then take them to school; my job is important but it's not obsessive, its healthy, my job's healthy, thank God. Otherwise food, sleep, laughing and connecting.*

In a joking manner Arthur managed to capture some of the key elements considered vital to the recoveries of the other participants. As he had already done on several occasions, Arthur gave a truly balanced perspective on what he thought was necessary to him on a daily basis. He was very aware of his tendency to invest too much energy in one thing and took joy out of the fact that he could be helpful towards his family.

Outside of his primary concern and focus, which was his family, Arthur also spoke about the importance of having a regular routine that he tried to stick to on a daily basis. This included eating correctly, sleeping well and dropping and fetching his children from school and getting to work. Similar ideas were echoed throughout the interview process. Ryan expanded on some of Arthur's comments:

> *I'm still very affected by things like how much sleep I get, how I eat, getting exercise like I find if I let my physical condition go you know and sort of basic maintenance of my surrounding, you know, like keeping my home tidy.*

Three of the participants responses to the question of, "on a daily basis what are some of the things that are most important to you" alluded to the importance of maintaining a physiological balance through sleep, eating correctly and keeping their home, in terms of their immediate environment, tidy. Besides being healthy behaviours, it would appear that these factors were indicative of a need for congruence in their lifestyles between what they believed in terms of their recovery experiences and the various behavioural expressions of this. Thus physiological ailments had the potential to affect them mentally and emotionally (Van Wormer & Davis, 2008). Although physiological ailments can be considered fairly normal for most people; the lack of flexibility surrounding this practice seemed to demonstrate an extreme sensitivity to their daily demands and changes within their daily

schedules. This appeared to be consistent with their need for conscious self-improvement on a daily basis. To further demonstrate Gideon said:

> *I like my ritual in the morning; I've been doing this right from the very beginning since I had a job, get up have my coffee, read my just for today and then I got another from the Rabbi. Rabbi Twerskis book so ya, I read those two books in the morning, shower shave make sure my beds clean, 'lay teffilin', which I learnt to do back in the rehab and then go to work.*

Gideon included a spiritual element in his daily affairs. Research has clarified that many members of 12-step self-help groups view the 12 steps and associated spiritual practices as providing guidance for a way of life with spiritual processes such as a relationship with a higher power or God as essential (Arnold,Avants, Margolin & Marcotte,2002). According to Galanter. (2006) spirituality is something that is experienced subjectively. In contrast to religion, spirituality can be classified as a latent construct in that it is not observed directly.

The fellowship of AA is generally understood to be a spiritual programme that does not have any theology or dogma (Alcoholics Anonymous, 2001). Many people in recovery describe the importance of believing in something spiritual, having faith in a higher power that will help them in their recovery journeys. Belonging to a faith community represents important pathways to recovery for some people. Spirituality also offers people a way to avoid uncertainty (Galanter, 2006). The state of mind that the participants' were trying to achieve in the morning was related to a sense of control that there morning rituals gave them, as were the participant's pre-occupations with other daily physical concerns.

With the assistance of some spiritually orientated books and some more religious practices including prayer Gideon aimed to achieve a certain state of mind before leaving his home in the morning. Starting the day off in the correct frame of mind was incredibly important to the participants. It seemed to centre them in a very particular way, before they headed out and took on the day's responsibilities.

Both Garth and Gideon's statements emphasised the importance of participating in certain rituals before going to work. It seemed that there was a goal at some level, to achieve a sense of certainty and clarity of mind before engaging with the day's responsibilities. These behaviours were also practised throughout the day with certain of the participants speaking

about more general features of their routines also being very important to them. As has already been mentioned interference with this routine was experienced as highly disruptive to the participants. There was an underlying fear to engage with behaviours that bore any kind of resemblance to what they experienced during their active-addiction periods. For example in Bryan's interview, he explained that every person in early recovery needs to spend their time constructively and that getting a job is one of the best ways to do this (Charney, et al, 2010). He said:

> *Getting a job!!! Financially any addict trying to recover needs to have a job and a constructive way of living every day. Financially they need money and that's good for their self-esteem and for whatever else they need to do.*

Brian discussed the importance of having constructive activities to do each day and maintained that being able to earn money improved self-esteem. The psychological impact of chronic substance abuse has already been discussed and so the researcher found Bryan's statement about the need for work appropriate because he was speaking about the need to achieve a level of structure that had been absent from many of these participants lives in the past (Rollins,O'Neil,Davis & Devitt, 2005).

In conclusion, many of the participants felt that having a daily routine was of paramount importance. Once again this seemed to be related to their (the participants) constantly developing capacity for self-care. Achieving a certain state of mind through a variety of practices including prayer, spending time with their family and staying healthy physically were all considered to be vital practices in their everyday lives. These accounts also demonstrated the seemingly timeless nature of their recoveries in that their attempts at self-improvements never ended (White, 2007).

4.2.4: An alternate social network

Coming into recovery many of the participants felt alienated as a result of their active addiction periods. Therefore finding forms of emotional and social support was an essential factor in the maintenance of their recoveries. In addition to developing support structures in the participants' lives, many of the participants felt that they lacked the necessary skills to engage with new social circles. The support groups that they attended performed an essential role in teaching these individuals essential coping skills that would later allow them

to better engage with life outside of these support groups. Some of the participants had very little support from family members and other loved ones making it very difficult to draw on social resources that were once readily available. Entering into a new social support group that provided continuous and unconditional support also gave them a sense of being able to muster important supportive resources, especially in times of pain and struggle. Gideon explained the immense value of developing relationships in this support group. He said:

> *The biggest thing since when I got clean has been the people that I got involved with and that I made friends with especially in the first ten years.*

Gideon was adamant about the need to develop relationships with people in these self-help groups from early on in the recovery process. His comments are in keeping with Onken et al's. (2007) position that human connection plays a central role in the recovery process. Support from others in a way that is loving and patient, gives the individual the strength and confidence that they need to recover. Gideon has been abstinent for 17 years and even though he has managed to build a very successful life, he still feels that developing healthy relationships was perhaps the most important cornerstone that helped him in his recovery. Garth explained that through simple connection with someone he could trust could relate to had been one of the greatest positive impacts on his life (Chavis & McMillan, 1986). He continued:

> *My recovery partner is still my mate Peter (pseudonym) and we've moved on and I've found that that was the most therapeutic kind of way to deal with this thing and at no time, no time did I ever like kind of look back, we just like go swept away with recovery and that was the greatest part about it.*

Brian also felt a great need to remain connected with the 12-step fellowship. Brian was a very successful businessman but his work forced him to travel very regularly. Dealing with this had been one of his greatest challenges. One of the reasons that it was difficult for him was because he had to work in a country where 12-step self-help groups were not readily accessible because of the varying religious denominations that were present in that country. In short these religious denominations appeared to conflict with the growth of these

fellowships because of apparent ideological conflicts. Thus Brian had to exercise other means of staying connected. He said:

> *I just been at my old rehab sharing and the group down there which is really one of the most helpful things; so my old rehab asks me to go in there every time that I'm here and that's probably one of the biggest things that's helped me cause when I was a year clean I phoned up, obviously I was back in Dubai, and really it was out of nostalgic value you know and I just wanted to connect with them.*

Brian felt a great need for connection in his life and his work often made him feel isolated. As an attempt to compensate for this, Brian actively contacted the rehabilitation centre where he had managed to become abstinent and had received treatment, so that he could connect with people that were undergoing their rehabilitation. Because so many of their more intimate relationships had been severely damaged throughout their addictions, the process of rebuilding trust with family members and other relationships that had been damaged was a process that took many years for some of the participants. In this way, Brian found that having access to a group of people who shared some similar experiences was very helpful to him. To demonstrate Garth Said:

> *Social networks have also been really important and I think that one of the real important things about NA that we were talking about is that it provides an alternative social network you know.*

Garth explained that some of the relationships that he had developed through meeting people in the 12-step fellowships that he attended were very important and meaningful to him. Even after many years of abstinence and recovery he had made a lot of effort to develop and maintain these relationships. It was through exposure to these relationships and the things that he learnt and internalised here that he felt led to significant shifts in his behaviour patterns (Visser, 2007). The value that Garth and other participants derived from active participation in these fellowships seemed to be primarily orientated around hearing similar experiences and being able to positively identify with other people. Martha said:

> *It was good for me to be with other addicts because I knew that they had been to the same place that I had been to and that we could connect with each. We were people*

that couldn't use any substance and that shared a common similarity because of that.

Inherent in Martha's comments was a sense of loss. She felt that using substances was no longer a reasonable means of coping with the anxieties and fears that had begun to surface since becoming abstinent. Being around other people that were either undergoing similar processes or had gone through experiences like this in the past provided Martha with some level of comfort. She could positively identify with the experiences of other people attending these fellowships in a way that she felt safe with. There was the perception that she was similar to other people in this setting and this gave her a shared emotional connection. Related to this was the sense of hope that Martha got from being around people with similar experiences (Onken et al, 2007).

For the participants hope simply meant that through participating in this fellowship life could hold more for them than it had held before. It was clear that through witnessing other people speak about how they had managed to recover motivated Martha to participate in this fellowship. This in turn inspired a desire to further commit and pursue their recoveries. On a related note, Garth described his sense of mistrust before becoming abstinent. He did not feel comfortable with asking other people for help and tried to deal with his problems by himself. He said:

Something that I was never able to do before I came into recovery was the ability to ask people for help.

Garth felt comfortable with asking other people for help and prided himself on the ability to do so. He viewed this capacity as a great step forward for him. There was thus a degree of interdependence evident in what he perceived to be the value of attending these fellowships (Visser, 2007). He felt more comfortable with the idea of being vulnerable and being able to speak about his problems. Dalton, Elias & Wandersman. (2001) maintain that social support can play an important role in dealing with stress and promote several other forms of psychological wellness. It was clear from what the participants said that a lot of the value that they perceived in their participation in the 12-step fellowships was orientated around coping with stresses of both everyday life and previously unresolved issues. Garth Stated:

So if I had stopped drinking and stopped using drugs without NA, I wouldn't have had anything to do because every single person I know used, well drank or used drugs, our social scene was structured around drinking and using drugs.

It is important to acknowledge that not all of the participants shared the same sentiments about the function and value of attending self-help groups in their lives. As has previously been discussed, Sara had experienced a sense of complete loss and despair when coming into recovery. After realising and truly observing the state that her life was in she felt that the damage caused by her addiction was irreversible. She described how she needed a false self or front to cope with life and that initially drugs made this possible. This was one of the payoffs of using substances that allowed her to cope and that were so difficult for her to relinquish once sober.

Part of her rock bottom experience was that she did not have access to 12-step rehabilitation when she became willing to seek help. Although she later utilised the 12-step framework as a means to maintain her abstinence, in comparison to the other participants she showed a surprising lack of interest in how she did. It as if she had reached a point where she did not need to think about the journey she had undertaken. She understood that this was her journey, in the sense that it was what she needed to do, but for her it was not about anyone else. The sense of alienation and hurt was evident in Sara's story. She said:

I started kind of just started trying to dig into a place and started just forming a foundation.

Sara had made a decision that becoming abstinent would help her to deal with her other problems but as opposed to many of the other participants, she did not appear to have as much of a clear sense of purpose regarding the potential value that this fellowship would have for her. Rather she viewed attending the fellowship of NA as something that she had to; as a rite of passage. Rather than a resource that she could develop and draw on for her personal development; it was really a case of her being entirely out of options. It appeared that the conditions under which she entered into this fellowship were quite different to the experiences of the other participants. She said:

NA was a really shitty place for me to go to because my husband and his new girlfriend would be sitting together an I'd be like sitting on the opposite side of the room and you know NA is a really toxic environment at times if you're in the wrong space but I just thought I'm going to stay, you guys do like whatever you want. I had a very strong sense that if I did not stay there I was actually going to never live I mean it was going to be over.

Sara was therefore forced through circumstance, to make decisions regarding how best to proceed with her recovery. Her efforts at remaining abstinent were based on preventative measures where she simply tried her best to avoid her previous lifestyle. One of the fundamental problems of Sara's scenario was that she could not receive the individualised treatment that she so badly required. Although the self-help group that she attended did help with basic issues like becoming and remaining abstinent her individual needs were not taken care of.

However, certain of the participants cautioned against wanting to grow too fast. Although it was important to always be moving forward psychologically and emotionally and to engage with different types of learning, sometimes taking on new pursuits could result in a feeling of alienation if it was done too quickly. Thus the process of growth had to be gradual and guided. Ryan explained:

There have they been like brief periods where I've let go of like a lot of supports at the same time; it only takes a week or two to start to feel a bit like you know unmanageable and you know a slight feeling of not being grounded.

The need for some kind of support was evident in Ryan's comments. Ryan was explaining that at a given point in time he needed some level of proximity to the support structures that he used while in early recovery. Even after many years the need for structure and guidance was evident in his comments. What he said served to re-enforce the gravity of what the participants had previously undergone. At no point did he entirely feel safe and free from the potential threat of relapse back to substance use.

This section makes clear the fact that recovery is not a process that happens in isolation; at least not for this group of people. As was evident in Kayla's comments, her ambivalence regarding her substance abuse did not allow her to draw on this valuable resource.

Participation in such mutual aid groups gives members a feeling of worth; that they have something to offer others. It also allows them to see aspects of themselves that they may not have not seen by themselves. They learn more about what they are capable of and aspects of what and who they are, which, ultimately, contribute to a change in identity. There is thus a shift from being an addict to being a worthwhile person.

It appeared that the activities that the participants got involved in, including service, gave them a sense of purpose that was previously lacking in their lives. For this reason they found a niche in their community orientated self-help groups. The perceived pleasure and rewards that came from engaging in meaningful activities helped to foster a sense of agency, a self belief that that the person can impact on their own life, and impact on the lives of others in a positive manner on their journeys of recovery.

These activities ranged from employment to volunteering, engagement with hobbies or other leisure activities, or connecting with other organisations or groups. Through these activities the participants were able to learn better communication skills through the multiple interactions that they had with other members in their support groups. Now that they were abstinent they were able to develop their problem solving capacities because they were able to learn through experiences. Obviously the role of social support cannot be underestimated for it was this factor that enabled the participants to take positive risks that may or may not have resulted in growth and other positive changes in their lives.

The participants' accounts in this section demonstrate that the recovery process promotes the inclusion of other support systems as an essential counterpart to the social marginalisation and stigma that are often associated with substance-related disorders. This appeared to be done through emphasising the roles which the participants played in terms of the service that they rendered in their support groups and rehabilitation centres as meaningful practices (Onken et al, 2007). The findings here help to conceptualise the recovery process in a non-traditional way which emphasises interconnectedness between individuals and their various support structures and the key roles that individuals in this role play. The participants' accounts offered a conception of the recovery process that goes beyond a reduction in substance use and expands the concept of recovery other factors that play an integral role in the recovery process (White, 2007).

4.2.5: The Recovery Process as a Metamorphosis

After hearing about the way in which the participants had developed on a material level they went on to describe a set of deeper level changes. It was not possible to confine these changes to just one thing. Rather these changes demonstrated a multitude of new attitudes, interests and behaviours that were previously not present. These changes were expressed in a number of ways. At the core of it all, what was found was that they had all undergone profound growth and healing. Their constructions of recovery shared several common elements that were related to the frameworks that they had initially utilised and learnt about in the rehabilitation centres that they had attended.

Arthur explained that materially what was important to him was that he had, '*enough*'. He said: "I got enough money and enough things, like I don't really need stuff, materially I am comfortable". His notion of enough was very much related to simple comforts in his life but also primarily to the well being of his family and being able to adequately support them. Things such as food, housing, transport and being able to pay school fees for his children were of paramount importance to him. Arthur distinguished between what he termed ,"the surface level things" and ,"deeper level stuff". Arthur's accounts seemed to suggest that the way he defined his recovery was related to the central conflicts that he was faced with at different times in life. He said:

> *There are the surface things, like money and then deeper things, like more self-worth.*

Arthur felt that the material gains that he had made in his life were important but they did not represent his recovery at a deeper level. The "deeper level stuff" that Arthur described in his interview had a lot more to do with how his perception of himself or his self-image had changed since achieving remission from his substance-related disorder. Arthur put forward this idea in the context of trying to quit smoking cigarettes. He explained that attempting to stop smoking was an act of self-care that was indicative of how his capacity to care for himself had developed. So, Arthur's definition of recovery contained an evolutionary aspect. Whereas initially things like money and other material assets were important to him; over the years he had grown content with what he had and appeared to be very satisfied with where he was. To further illustrate the growth that had taken place in the lives of the participants' Edgar said:

I don't need to spend money all the time to make myself feel better because I'm actually quite content and happy with where I am, so my inside has had some healing and my behaviour has changed.

Like Arthur, Edgar was no longer fuelled by an uncontrollable desire to achieve more in his life. He was content with the point that he had reached and now his process of recovery was orientated around other things like his spirituality and his family. Both of these men described how they now had less of a need to make themselves feel better with external things. Although simple, being able to derive a sense of comfort from internal factors such as a belief in oneself and being able to take care of ones' family had significant implications for the lives of these participants. Because they were no longer so preoccupied with external things like money, assets and other material interest, they were able to invest more energy in healthy and intimate relationships. They have both been happily married for many years. This is not said to undermine the role that financial well being can play in the life of an individual and it does not mean to suggest that being married represents the only barometer for assessing ones capacity for intimacy.

Moving forward, the researcher now draws on his interview with Garth. At this point the participants' views diverged. The researcher felt that Garth described his recovery in terms of some of the factors that are commonly considered when evaluating and defining a recovery from substance-related disorders (Mclellan et al, 2005). He said:

Obviously this is like self-diagnosis you know; as an addict it was self-diagnosing that I was unable to stop using alcohol, I was unable to stop using drugs, and I needed help in order to do it.

Garths comments bring to light several important factors that are worth considering. In the first instance he explained that where his substance-related disorder was concerned it really was a matter of deciding for himself that there was a problem (Ziedonis, 2005). As has already been discussed in an in depth manner, little can be done without the individuals deciding for themselves that they have a problem, and being willing to receive help for this problem.

Not knowing how exactly to achieve remission for their CODs also indicates that the responsibility of coming to this realisation rested completely on him. It was his responsibility

to determine that his substance use had reached a point where it was problematic (Sterling & Weisner, 2005). At that point in time, he felt that arresting his drug-use was the first logical step forward. As such, this man initially viewed his illness primarily in terms of substance-use. His also originally defined his "recovery experience" in terms of substance cessation, including alcohol (McLellan et al, 2005).

The definitions provided in this sub-section varied greatly from one another. Material advances appeared to be of paramount importance to nearly all of the participants. The only interview in which a participant did not flagrantly emphasise the material advances that he had made his life was the researcher's interview with Brian. Unlike the other participants, Brian had not arrived in a treatment centre in a state of financial ruin. Coming into recovery Brian had remained very successful on a financial level and although he had experienced several significant losses as a result of his addiction he did not regard material loss as a significant factor of either his active addiction phase or his recovery. His description of what recovery was for him was more related to the losses that he had described during his interview.

Thus things such a loss of values and principles, the inability to nurture loving relationships and a sense of alienation that he had begun to experience in the later years of his active substance use were all related to how he chose to define his recovery. He said: "having my kids back in my life is great". This is one of the major factors that Brian chose to define his recovery in terms of. For this man the reparation and the retrieval of significant intimate relationships was at the core of what he understood his recovery process to be about. The participants had experienced recovery as a multi-dimensional process. Some of the participants posited that recovery was about finding out who you are while others described recovery as creating a different life all together.

The discussion now turns to those factors that represent a deeper level of change. As shall become clearer, at different points in time the participants viewed their recoveries differently. It was also clear that the recovery experience was related to many different factors. Up until this point no one strategy or approach to recovery was prioritised. Common thoughts and ideas were discussed but the researcher felt that it was essential to look at each of the participants' recovery experiences individually. The researcher was deeply touched by how the participants had managed to change their lives. The participants

appeared to conceptualise what they had gained from their recoveries on a continuum which some of them described in terms of physical or surface-level benefits and deeper-level benefits. The most common of these changes was related to the level of material development that they had made in their lives.

Some of the surface-level changes that were characteristic of these participants' lives have been discussed. A parallel was drawn between the concept of primary suffering and the surface level changes that were related to material acquisitions. These changes shared a common theme in that these surface level changes were very often described as symptomatic changes that did not entirely reflect the true nature of what they felt recovery was. Like primary suffering, the initial changes that the participants experienced can be understood as a consequence of an internal change, rather than the true change itself.

Initially there was a turning point that was characterised by a need for complete abstinence from substances. However later on in their recoveries there were other turning points as well (Dennis, Foss & Scott, 2007). As opposed to the earlier years of their recoveries these turning points differed radically and will now be discussed. The responses to what the participants felt was necessary for sustaining and developing their recoveries. The participants used different resources at different times to help them in their journeys. Upon careful analysis, however, the researcher found that there was a definite need for growth throughout their recovery processes. Many of the participants described a scenario wherein their 'addictive energy' was still present in their lives. Although they had now achieved abstinence they described the constant need to channel or sublimate their excess levels of energy.

In the greater context of the interview process it became clear that these significant changes should be viewed across the lifespan. They were too broad and too complex to definitively compartmentalise into categories or mini-themes. However, a common theme that persisted throughout the interview process was that the definite need for growth in all of their recovery experiences (Galanter et al, 2005). How they achieved this growth varied from participant to participant.

Longer-term recovery was characterised by several changes and/or transitions. It seemed as though certain of the tools that the participants chose to use had a certain but limited

usefulness. This means that the tools that the participants had used across their recovery life spans were appropriate for certain periods of their recoveries but less so for others. Over time many of the tools that the participants utilised acted as reminders and principles that were pleasant to reflect on rather than driving forces in their recoveries. Ryan explained that at different times he had utilised different tools to help him negotiate the challenges that he was faced with in his new life. He said:

> *It's almost like a little continuum; in the early days I thought that the treatment was the key thing and then NA but over the last 5 years I've also become very involved with yoga and that's become a very like absolute key component.*

Ryan had developed many interests over the course of his recovery. He had reached a point where his recovery focal points had changed greatly. He spoke with great clarity and certainty. He concisely described what drove him in the later years of his recovery and he was able to reflect on the role that each tool that he had utilised in his sober life was for. Over the years what appeared to be of paramount importance was the need for connection with other people. Ryan also demonstrated a capacity that was present to some extent in all of the participants but the degree to which this was the case varied greatly. Ryan it seemed was able to internalise the values and principles that he had learnt through rehabilitation and his subsequent engagement with NA. This was greatly indicative of a deeper level of health (Dodes, 1990). However these changes did not take place all at once thus Ryan stated," I've tried not to make like a radical change all at once".

Ryan had developed what can be termed ,"recovery capital". This term refers to a collection of resources including health, mental health, strong family relations, that can be accumulated over time and as abstinence is sustained (Dennis, Foss and Scott, 2007). Ryan's comments also demonstrate that recovery can consist of many activities that connected with, describe and help to interpret this complex process (Ralph, 2007). The primary source/activity that the participants' drew on was deeply orientated around the 12-step framework. In the context of this thesis the 12-step fellowship can be seen as a tool that provided continuous social and emotional support as well as valuable information on the nature of the participants' illnesses. Ryan had attempted throughout his recovery to develop all of these potentials in his desire to live a balanced and healthy life. However, he explained that the process could not be rushed. Much of the time his recovery was

exploratory in the sense that he picked up tools as he went along and held onto only what he found useful. He provided an excellent analogy for recovery describing his recovery process as a 'chameleon walk'. He said:

> *It's been like a very slow evolution for me, for me, a stable sort of sustainable recovery like it feels almost like a chameleon walk, we only ever have like one foot off the ground and we'll like test and then put that foot down.*

Thus it was important for Ryan to feel safe throughout his recovery. His comments suggest a need for minimal risk in his endeavour to maintain and develop his recovery. Only once feeling safe about a possible course of action, could he then move forward. Although he was assisted by the various support groups that he attended there was a sense of not knowing what to expect from changing his direction or exploring new things. Ryan had to work towards understanding in his life. Rather than passively coping with new experiences Ryan had actively engaged with the recovery process by learning to experience and find pleasure in new things (Ralph, 2007)

Ryan's comments demonstrate in a very broad way the fluidity of the notion of recovery. They demonstrate that recovery is a multidimensional construct. The discussion now moves to more specific factors that facilitate the process of recovery. It has already been discussed to some extent that the group of participants that were selected for this study were drawn from several 12-step meetings. Naturally all of the participants attended the self-help programs of AA and NA in the early stages of their recoveries on a regular basis. Essentially the participants attended these programmes in order to maintain their abstinence from substances. However, a whole range of secondary benefits existed that the participants derived from attending these programmes.

It was argued that the active addiction phase resulted in an estrangement from the self. The participants' preferences and interests were severely inhibited by their active substance abuse. Therefore, one of the reasons that the participants felt that participation in one of these fellowships was so important was because it offered them a framework through which to understand their illness better. 12-step frameworks utilise a disease concept for understanding substance-related problems and as such the transfer of certain core ideas is guaranteed through continued exposure to these fellowships. Some of these ideas include

describing the substance-related disorder as a disease and the idea of a moral and spiritual cure. Micheal explained:

> *The 12-step fellowship has been of great value to me and it's kind of given me a framework in which to pursue my life in recovery.*

Like other participants Michael expressed a deep interest in coming to understand why he was the way he was. Having gone through the process of,"rock-bottom", Micheal arrived in recovery not knowing anything about himself. Much of his journey through recovery was orientated around learning to better understand his illness and the various manifestations of it. Similarly Edgar described a great desire to better understand his illness and other relevant things in his life. He said:

> *I realised that things that I have been struggling with, there have been books written on them 10 years ago, and I thought I m so special and different and no one understands me and I m lost, so I'm like reading some psychological books, I like reading Christian books, recovery books ,business stuff and biographies.*

Through actively taking steps to learn more about himself and the world around him Edgar read many books. After some time he realised that his problems were not as unique as he had led himself to believe. Edgar was speaking about a new found willingness in his life to examine and explore all sorts of different things. Previously Edgar did not have this capacity. He said: "when I was using uh, I couldn't look much further than a simple novel or some porn". He described his desire to learn more as a hunger for knowledge that was related to learning more about himself and considering different methods of recovery in his life. Edgar explained all of this with a sense of humour but underlying his wit, the researcher felt that that there was a deadly earnestness. It was not just Edgar's interests that had changed but the way that he approached life. Previously he had described himself as being arrogant and promiscuous, never being able to find fulfilment in anything. His thoughts here truly demonstrated a significant shift, as he now approached life with an attitude of humility and openness to new understandings.

In order to contextualise what has been said here the researcher revisited how earlier Garth explained that he was unable to stop using substances by himself. This inferred the gravity that he attributed to his substance-related disorder. Acknowledging that he was not able to

stop his substance use by himself was also an acknowledgement of his human limitations. Conceding that he required help for his problems was somewhat uncharacteristic of the way that he had described himself earlier in his life (Galanter et al, 2005). Like Edgar, Garth had changed his attitude towards life. For example, Garth explained that one of the only regrets that he had in his life was that he did not seek help sooner. He said:

> *I wish I hadn't been such a know it all, I thought that AA and NA and 12-step program were just people trying to trick me into believing in God and I wish I had been more open, more open minded earlier on.*

Garth sounded frustrated when he said this. He realised that many of his previous convictions were not helpful to him in his endeavour to improve his life. He explained that his arrogant demeanour had interfered with his ability to seek help. Thus conceding that he had a problem and admitting that he needed help in order to deal with it represented at an internal level much more than simply stopping his substance use; it represented a shift in trajectory from an arrogant, aggressive and defensive demeanour to a humble willingness to face his problems. Moving forward, Kayla described her recovery in terms of several factors. She said:

> *I have real relationships; all of my relationships have improved. My intimate relationships, my relationship with my family, my colleagues, and my friends are all completely different.*

One of the ways in which Kayla defined her recovery was in terms of relationships. She described the change in them being so great that it was completely different to what it was in the past. However she readily acknowledged that she still had much to work on. For example she mentioned that she had struggled to express herself in the past and that this had impacted on her past relationships. However part of her definition of recovery was located in her awareness around issues like this and her willingness to work on these issues.

She also explained her relationships as being real. Although Kayla described her relationships as being completely different she did not describe them as being perfect. She explained that one of the chief differences between now and her previous life was that her tolerance for ambiguity and pain in relationships had improved. This again demonstrated her acceptance around the various issues and problems related to her disorder.

It seemed as though all of the participants did in their own way see having recovered from CODs as beneficial. They had few regrets about their previous lifestyles and many of them suggested that their becoming abstinent had offered them opportunities that otherwise would have not been available to them. For example Kayla said:

> *I'm almost grateful that I'm an addict because it's opened up those avenues which were completely shut off or concealed when I was in active addiction and when I was unaware of what going on with me.*

Thus Kayla felt that there were benefits to having suffered from a mental illness and having achieved a state of remission from her disorder. She explained that there were new opportunities in terms of work that were previously not available. This was related to her previous pre-occupation with substances. She could now act on these potentials and opportunities. She also explained that through a deeper awareness of her issues she was able to deal with her problems in a better way. Kayla's comments also make clear a sense of purpose that was not previously there.

Self-awareness was definitely something that all of the participants prioritised in some way. Being able to have perspective on things that were relevant to them gave them a certain level of mastery in doing this. In this study no definition was better than another. What was important was that the participants all assumed that the researcher was asking them, "How would you define recovery"?

In conjunction with Kayla's improved 'pain threshold' regarding emotional discomfort, Ryan spoke about recovery primarily in terms of his enhanced capacity to cope with life. He said:

> *I have structured ways of dealing with things. I now have better tools; my life is completely different now. I have structure, balance, and more self-confidence. I am successful at work; I've been in the same job for 6 years.*

Ryan provided a 'point blank' definition of how he viewed recovery. Although he made several comments regarding the nature of his recovery and what it was; his thoughts were primarily orientated around how his capacity to deal with life's' responsibilities had improved. For this man routine and structure was of paramount importance. He spoke about the fact that he had remained in his job for several years with a sense of pride and

achievement. For him, being able to remain in the same job for an extended period of time reflected continuity in his life in terms of his behaviour as well as his emotional and psychological state of health. These positive changes were explained as unique to his recovery and his new lifestyle.

Moving forward, Hanna explained that her recovery should be looked at in terms of integration. Her substance abuse had left her alienated and feeling as though she was a pariah. Recovery to her represented a shift towards a reintegration with other people and this took place at a number of levels. She openly frowned upon her past behaviour. Recovery also meant less negative consequences. She took pleasure in the fact that her life was now simpler. She also expressed a sense of relief regarding how she no longer had to fight against what was happening in her life anymore. She said:

> *I feel like I'm a part of the system rather than fighting against the system and being a victim of the system and misunderstood so now I feel that life's got simpler and I can just get on with life like everybody else.*

Alternatively Brian explained that recovery was all about having choices. For him it was not necessarily always about making perfect decisions but rather it was about taking positive action in his life and accepting the consequences of his actions. Brian's definition of recovery was largely orientated around options that were now available to him in his life. He said:

> *I got a lot of freedom and I got a lot of choices. That's probably the biggest thing is the amount of choices that I have. I'm quite happy to make decisions and bear the consequences if they come. I enjoy it.*

In reflecting on how his life had changed Brian demonstrated an acceptance of his life's difficulties. The apparent absence of fear was evident in what he said. He felt comfortable with facing challenges head on. His account illustrated a significant contrast between the fearful and anxiety ridden person that he once was. In recovery he had learnt to take responsibility for his decisions to the extent that he actually found this practice fulfilling. Similarly Michael explained:

I'm able to maintain some decisions based on a little bit of experience and I'm able to do insanity checks on my thought processes in in those decision making processes and with a bit more of a balanced view.

Micheal described how his ability to learn from his experience had improved. He described how his ability to reflect on his thought processes had also improved. Micheal had previously lived in a world characterised by many fears. He did not trust himself and he explained that due to his substance use he was unable to learn from his experiences. In recovery he had developed the capacity to learn from his experiences and apply that knowledge in real life situations. He was now able to actively challenge thoughts that he felt were irrational or unrealistic by performing what he referred to as, ”insanity checks”.

As has been demonstrated, the participants made many different attributions regarding the nature of recovery. Their thoughts on the matter greatly diverged yet seemed complimentary to each other. Initially there was a common trend in that the participants defined their recovery experiences in terms of what they had lost during the primary suffering phase of their addiction. Thus the majority of the participants explained that material advances that they had worked towards in their lives were very important to them and acted at a basic level as a barometer for how they gauged changes in their lives.

The basic conclusion that can be derived from this is that recovery from a substance-related problem is not just one thing and can be defined at a number of levels. The views put forward by the participants' also suggests that the word recovery does not adequately describe what happens in the years after the participants achieve abstinence. The word, “recovery” implies the retrieval of something that was lost as was the case in Saras' experiences. However, many of the participants put forward the idea that they had actually gone beyond the people that they were when they were using substances.

Having suffered from CODs many of these individuals readily engaged in further forms of education to try to better understand the true nature of their illnesses. Thus the word ,“recovery” almost seems mechanical in the sense that it suggests a clearly defined path that one must negotiate rather than is suggested by the word, “healing” that allows space for the individual to actively participate in this process (Ralph, 2007). Thus, a substitute for

the presently utilised word of recovery may be beneficial to those that have suffered from CODs such as transformation.

It remains clear why it has been so difficult to present a consensual theoretical framework for addiction recovery. There are so many ways of defining the phenomenon that even attempting to do so runs the risk of omitting vital information regarding the phenomenon. However, through these sub-sections some of the major features characteristic of recovery emerge, including a healing process that in the case of this research spans many years.

This chapter indicates that the recovery process involves a constant adaption to life's demands and requires the interweaving of the elements of one's life context (Onken et al, 2007).The initial building blocks of recovery can often involve effective rehabilitation and a space in which to decide whether this is what they want for themselves. More abstractly the later years of recovery seemed to be overtly characterised by both a constant adaption in relation to the shifting conflicts that the participants were faced with up until the present point and the underlying idea of a profound search for meaning (El-Guebaly, 2012).

4.2.6: Preserving the memory

Even after many years of recovery the participants regularly referred back to the time before they entered into recovery. These accounts were not the same as the ones that they provided in relation to the suffering that they underwent. Rather these accounts were spoken about in terms of motivational factors that enhanced and maintained their recoveries.

These accounts were spoken about in a spirit of both hope and caution. It was clearly very important for the participants to remember what they had been through. Remembering here does not simply refer to that process of mentally retrieving a past experience. The remembering that is referred to denotes active attempts to relive the experience through relating to the experiences of other members in the support group. It can also be understood in terms of the first step of all the 12-step fellowships, which is, 'we admitted that we were powerless over our addiction/alcoholism and that our lives had become unmanageable" (Alcoholics Anonymous, 2001, p). As has been discussed, the steps are cyclical in nature, thus an individual who subscribes to this framework for recovery would continue to work them, even after having completed the 12th step. The awareness of having

given up a negative relationship and the intention to keep it that way was reflected in the way the participants actively fostered the memories of the negative aspects of their active substance abuse. The motivation behind such an act was informed by the belief that doing so would help to remind them of where their substance use would end up should they return to active substance use.

Remembering their past experiences and the label of 'addict' that came with it presented itself as a form safety strangely enough. Generally, the term addict has negative connotations that are largely associated with substance abuse and a wide range of negative behaviours that are very often detrimental to the individual using substances and the people closest to that person. It was argued that the acknowledgement of the substance-related disorder and acceptance of the label 'addict' was the original shift in trajectory.

It was also a 'secondary identity' that they were able to adopt coming into recovery (Johansen, Brendryen, Darnell & Wennesland, 2013). A, "secondary identity" is an appropriate term to use because initially the participants lacked the diverse set of skills required to interact with the world around them in a productive manner. Thus the support groups that the participants attended served multiple functions. These support groups were microcosms which imitated real life situations but on a much smaller scale. They were also, 'testing grounds' that made learning how to behave in different ways easier because of the loving and acceptant nature of these SHGs. Therefore, access to this support was an essential maintenance factor for the participants, even in the long term.

When confused, scared or lonely the participants could draw on their earlier experiences to compare where they previously were to the point that they were now at in terms of their lives. An awareness of this difference acted as a constant reminder of the progress that they had made like a lighthouse guiding a ship back to harbour. It also represented a process of renewal in a manner of speaking to whatever means they had adopted to prevent them from going back into active addiction. Above all, these attempts to re-connect with their earlier addiction experiences appeared to be an exercise in maintenance.

Understanding the need that the participants had, of understanding their previous experiences, helped to contextualise their recovery experiences. What the section entitled, 'A laypersons definition of recovery' made clear was that there was a tangible need and

desire for growth in their lives. The importance of making attributions regarding the nature of their recovery has already been discussed. To re-iterate, making attributions about their recovery gave them a sense of safety. In light of their great need to stay in touch with what their active addiction period experiences were, many of the participants' earlier statements regarding what recovery was could be seen as attempts to stay in touch with what they had been through.

This was explained to the researcher in terms of a predominantly spiritual framework. The entire sample of participants had some level of exposure to the 12-step framework. Actively living by the various conceptualisations that they had of it, kept them in touch with their addiction experience. For example Garth explained:

> *I remember what is really like, I remember what it was like when I was using and I know the difference in my life between now and then, and I never want to go back to then you know.*

Garth explained that he had recently received news of a friend that had passed away as a result of substance use. He went on to describe a series of depraved behaviours that accompanied the substance abuse. Garth could identify with some of these experiences and explained that he felt so grateful that he did not have to live like that any longer. So, it was very important for Garth to be able to meaningfully acknowledge the potential damage that substance abuse could cause in his life. This acknowledgment later allowed for/and facilitated the careful reflection of those experiences contained within the active-addiction period. Garth had reached a point in his life wherein he no longer felt the need to maintain the same level of proximity to the 12-step framework. In many ways this was indicative of the high level of functioning that he had managed to achieve. Ryan explained that even though he could now be considered to be in longer-term recovery he still made every effort that he could to remain in touch with this support network. He said:

> *I'm in my 7th year now I still do a regular meeting, so that's been like pivotal and I also got involved with the program in other ways, I still regularly go to rehabs and speak to patients, got other guys in the program that I sponsor, and all these things they keep me very connected to what it's like to you know.*

Ryan spoke about a sense of connection that he derived from staying in touch with his support group. He prioritised and valued the sharing of his experiences with other people that were much earlier on in their process during their rehabilitation stages. It also allowed him to visibly see the progress that he had made in his life. Through seeing their pain and suffering and being able to identify with those experiences, he was able to benchmark the progress that he had made.

It has been mentioned that attempts to remain in touch with their self-help groups can be considered a maintenance factor; that is an activity designed to help strengthen their individual recoveries. The participants felt that staying touch with their support groups reduced the likelihood that they would return to active substance abuse. Therefore preserving the memory of their addiction-related experiences was also a preventative effort on their parts.

In community psychology the term, "prevention" specifically refers to interventions that aim to modify processes and mediating conditions that create risks for problems in living. The concept of risk is therefore central to this definition. To a large extent the participants' views on what should constitute a healthy recovery were in many ways efforts to prevent these individuals from returning back to active substance abuse.

Because community psychology is concerned with social and community problems, and with how social systems affect the lives of individuals, the risk that is referred to in this instance is a statement about social contexts, not people (Dalton, 2001; Ahmed & Suffla, 2007). Thus, maintaining safety in the SHGs that they attended was a key priority to the participants given the deeply seated fears they had of people and/or social groups that may somehow negatively affect their recoveries. To demonstrate Ryan said:

> *There are things that I see around but that I don't engage with, so like I've you know like iv e kind of tended to like really stick with something that's working and you know I think I just haven't tolerated stuff that was not good for my recovery, I haven't, I don't have you know I don't spend any time with people who are in active addiction, I don't kind of indulge conversations that I know is kind of negative about recovery or kind of glorifies using.*

Prevention is not a static concept. It does not exist and operate in isolation to other values and principles in community psychology. Rather it is interconnected with other principles both at the theoretical level as well as the practical level. For example, prevention is often discussed in connection with health promotion. In order to promote health the risk factors that could potentially inhibit these conditions must be identified and subsequently intervened upon (Lazarus, 2007).

Prevention is inextricably related to the value and principle of individual wellness, which refers to physical and psychological health as well as the emotional coping skills to maintain that health (Dalton Elias & Wandersman, 2001). Importantly, there is an overlap between the fundamental values incorporated in prevention initiatives and those of clinical psychology. The similarities between clinical practices and mental health approaches have led some to argue that the model does not represent a sufficient shift from mainstream clinical practice (Ahmed & Pretorius-Heuchert, 2001).

4.3: Part 3: Die Soegenden: We are the searching people: Factors that are harmful to the recovery process

4.3.1: Relapse triggers

This is the final section of this thesis. Up until this point, the factors that have constituted the primary focus have been related to recovery from CODs. In this final section it is hoped that areas that pose potential threats to the recovery process can be illuminated. To begin, the need to identify and avoid certain relapse triggers was a common goal for all of the participants. As such, many of the participants also expressed an aversion to previous behaviours that they felt were drug-related. In keeping with one of Narcotics Anonymous axioms of, 'people places and things' many of the participants completely dissociated themselves from their past lifestyles in their attempts to recover (Narcotics Anonymous, 2001). To begin Ryan said:

> *I don't spend any time with people who are in active addiction; I don't kind of indulge conversations that I know is kind of negative about recovery or kind of glorifies using.*

Ryan felt that spending time with old acquaintances or even indulging in any kind of conversation related to drug use was no longer useful to him. Outside of this Ryan felt

comfortable with his life and did not feel it necessary to explore and/or rekindle any kind interest in this area (Petterson, Ruud, Ravndal & Landheim, 2014). Edgar described his experiences in a similar way, although for him the process had been more gradual. In Chapter 1 the notion of cross addiction was discussed and significant portions of Edgars experience were drawn on to illustrate how this phenomenon can play out during the recovery process. However, during the initial process of his recovery, Edgar did not frame his capacity for cross-addiction as threatening to his recovery. Ryan continued:

> *Making new friends new circles. Dropping all the old friends, dropping all the old places I used to go to. Dropping all the nightclubs and the bars and the wherever I used to hang out completely and utterly. Not clearly from one day to another but through the years.*

Ryan and Edgar had both arrived at the same conclusions but Edgar had taken much longer to arrive at this conclusion. Notably Edgar had not attended a rehabilitation centre and instead had used a combination of therapy and the 12-step fellowship to reach a point where he could effectively identify and manage what can generally be understood to be relapse triggers. Edgars' process of psycho-education regarding his disorder had been much slower than Ryan's but ultimately he had arrived at a similar view.

Kayla also felt that she was not able to continue frequenting the old locations that she used to use substances. It would appear that even after many years there was a latent emotional connection to the places that the participants used to visit while actively using substances. Relatedly, there was a concern and a tangible aversion to the various kinds of paraphernalia associated with using substances including crack pipes, rizzler to roll joints and smoke dagga and keeping alcohol in the household as just some examples. Kayla said:

> *Ok dangerous people, you know that whole sexy lifestyle, but I just had to say I'm out!!! I'm out!!! I'm not doing it anymore. It's quite hard to make that break cause I just love dancing and I would dance all night for like seven nights in a week if I could, and I had to stop all the clubbing and that whole scene.*

In this way, many old associations were viewed as dangerous to the process of recovery. A perception of danger existed beyond the actual possession of the substances themselves

and included people that they used to be friends with and the environment that they used to interact in. Even many years down the line, the participants still referred to fundamental methods of aversion as necessary to their recoveries. Thus the people that they used to associate with, the environments that they used to visit while using substances and obviously the actual objects/paraphernalia related to substance use were considered dangerous to their recoveries. Although all of these factors were taken very seriously, many of their concerns centred on the danger of relationships, especially during the early recovery period. Michael said:

> *I think that a relationship, picking the wrong romantic relationships has been dangerous and detrimental to me at times. I've gotten into a relationship once with someone who is completely self-centred almost to the extent of being nasty and doesn't give me the affirmation that I need and it got me into a very dark place.*

Michael's comments embodied the need that the participants had for supportive structures in their lives. There was a *'zero tolerance policy'* for any kind of behaviour that was inconsistent with what they felt was necessary for their recoveries and that did not actually support their recovery in some way. It was also indicative of common difficulties that people with CODs have with relationships. Owing to their predisposition towards things like significantly poorer social functioning, , more risky behaviours, having a poorer overall quality of life and generally, problems that are more complex, it was to be expected that remaining in a stable long term relationship, especially in the earlier years of recovery, would be very difficult (Fabricus et al,2008).Problems in relationships were further exemplified by the fact that unless entering into recovery either married or in a serious long term relationship, the participants were unable to engage in healthy long term relationships during the formative stages of their recoveries.

4.3.2: Stigma

> *Some addicts will abstain from drugs but will be unable to internalize the function of the idealized object, therefore requiring its permanent presence, as via permanent use of AA* (Dodes, 1988, p.416).

One of the central assumptions that this study puts forward is that every person suffering from a substance-related disorder has one or more CODs (Fabricius et al, 2008). Importantly CODs express themselves differently, with individuals suffering from these disorders often requiring unique forms of assistance (Torrey, Drake, Cohen, Fox, Lynde, Gorman & Wyzik, 2002). Furthermore treatment for these disorders often needs to be ongoing. In places like South Africa, individuals suffering from these disorders are often required to take personal responsibility for dealing with and educating themselves about their disorder/s. This accounts for what at first glance appears to be a set of recovery experiences that are not uniform. The exact time periods for which the healthy resolution of problems such as difficulty in the maintenance of personal relationships, greater identity integration, or simply the cathexis of healthy behaviours in the form of new interests could not be clearly elucidated because the sample used in this study were not all subject to the same treatment measures. This section deals specifically with the participants' relationships with the support groups that they attend/ed; while bearing in mind that those individuals with more severe CODs require the constant/ongoing presence of treatment and support in some form.

Having said this, the way that the questions in the interview schedule were structured gave the participants a choice as to whether they thought that the treatment or alternatively the neglect of other underlying disorders was relevant to their journeys of recoveries. In the interests of keeping these sections as simple as possible so as to avoid unnecessary complications, the researcher first looked at the way in which the participants responded to the questions that they were asked regarding what they viewed as harmful to their recoveries.

Owing to their level of identification with the frameworks that they had utilised in order to return to health and achieve a higher and more stable state of functioning there was a certain degree of resistance to these questions. Importantly, 12-step philosophy does not provide a framework for understanding any other forms of CODs. Thus, as lay-persons, they were limited to their own unique and individual understandings of these phenomena.

It was clear that those participants who had attended less psychotherapy in the past had a stronger identification with 12-step philosophy and consequently less of a capacity to

engage with the implications that other underlying disorders and conflicts might pose. There was therefore a very clear tendency, with those who had engaged with less rehabilitation to demonstrate a greater reliance on support networks for a greater period of time. Conversely, those in the sample who were willing and able to access more advanced treatment measures illustrated a considerably greater degree of flexibility regarding the resources that they chose to utilise in their attempts to deal with their disorders (Moos & Moos, 2006).

Considering that the COD phenomenon is a relatively new construct, even in professional circles, it was to be expected that the participants might struggle with discussing how their CODs impacted on their recoveries. Therefore the researcher did his best to look at the accounts put forward as unique experiences, always remaining attentive to every change in tone and without generalising norms from one participant to another. The one exception to this of course, was where participants who shared the same COD were concerned. In these instances the researcher found it useful to compare their experiences.

After careful reading, the researcher decided that using their level of identification and dependence with and on these self-help frameworks was an appropriate way to start wading through some of the factors that the participants found detrimental to them. Through doing this, various inferences about their previous level of psychopathology as well as their present condition could be made in a more informed way.

The participants responded very differently from one another throughout the interview process in relation to questions that offered them the opportunity to speak about some of the things that they did not find helpful. In relation to the questions of:

1) Tell me about some the things that you have not found useful or detrimental to your process of recovery?
2) Knowing what you know now, what are some of the things that you would have used/done earlier on in your process that you didn't and that have helped you in your process?

Many of the participants struggled to answer these questions. Some of them actively disengaged with these questions while others required what was felt to be an unusual need

for clarification regarding what was being asked. Some of the participants were even irritated by these questions. To illustrate Daniel said:

> *Are you talking about concepts within NA? I've found nothing that's detrimental. It's been smooth sailing ummmm no it's been smooth sailing.*

Daniel had been abstinent for 14 years and explained that besides a few health-related problems he had experienced no other difficulties. The interview questions did not specifically enquire about the nature of their (the participants) relationships with either AA or NA and so it was strange to find such a radical shift in the tone of the interview. In trying to clarify what the researcher was asking, Daniel thought that the researcher may be questioning how well he understood 12-step-related concepts. There was an underlying aggression and impatience evident in Daniel's response.

It appeared that Daniel felt that the researcher was questioning his recovery by asking about the difficulties that he had experienced. He seemed to equate the questions related to some of the difficulties that he had experienced in his recovery, as an interrogation of his loyalty to his support group. Besides an obvious unwillingness and maybe even a fear of being vulnerable, Daniel perceived the question as stupid. It is important here to remain cognisant of the parallel that can be drawn between what was taking place during the interview with Daniel and the earlier section that related to the participants not being able to achieve abstinence partially because they did not know of any alternative. The same can be said about the certain of the participants' rehabilitation process, with some having attended only a bare minimum while others had attended extensive levels of personal therapy and treatment. Daniel then went on to explain that throughout the entire time that he had been abstinent he had experienced no problems. He continued:

> *Look for the first 5 or 6 years I was probably at meetings 3 or 4 times a week and then I must admit I'm only going once or twice a month now but I mean I never skip. I still make sure that I'm at meetings regularly so what I'm saying is that that I've integrated NA into my life and what I'm saying is that NA is not the overwhelming predominance of my life and I don't tell anybody about my position regarding NA anymore because I think it's irrelevant.*

Daniel was defensive and sounded angry (Tripathi, Phookun, Yadav, Strivastava & Talukdar, 2012). It seemed to the researcher that it was important for Daniel to present himself as 'ok'. There were similarities here between some of Sara's earlier definitions of recovery and her need to present all of her achievements as acceptable but there were also important differences. The question it seemed, led Daniel to an unfamiliar place. There almost appeared to be a sense of guilt and shame around not presenting his recovery as anything but perfect. The questions being asked seemed to touch directly these very sensitive areas. Upon being asked about any difficulties that he had experienced in his recovery, Daniel understood the researcher to in fact be asking him whether he was fulfilling his obligation to his recovery.

He began by saying that he was still highly active in this fellowship, yet he also explained that he had been missing meetings quite regularly because of various work obligations that he was pre-occupied with. He then went onto explain that his life was not orientated completely around NA anymore and that he didn't need to explain it to anyone anymore because it was 'irrelevant'. This response perplexed the researcher. Daniel quickly disengaged from the subject and remained silent, indicating that the researcher should continue with the next question.

At this point Daniel appeared to be highly self-conscious and the atmosphere during the actual interview became uncomfortable. It appeared that Daniel felt that he had said something that he shouldn't have and was now trying to correct it. Through answering the interview question it seemed that Daniel had unwittingly stumbled onto a sensitive area that he chose to completely deny (Glass, Williams & Bucholz, 2014). It was so important that he showed the researcher that his recovery was fine as demonstrated by his description of the relationship that he had with the programme.

At the same time he wanted to show a certain level of independence in his life by explaining that he had internalised the programme. The researcher surmised that the shame-based response popped out in relation to him realising that he had actually been attending meetings irregularly. Clearly this made him feel threatened and afraid in some way. In correcting this Daniel made sure to compensate and explain that his recovery was still healthy and moving in the right direction. To further contextualise this issue, a central tenet

of 12-step philosophy posits that substance dependence and/or addiction is actually an ongoing and progressive disease. As such a substance-related problem can only ever be arrested and the maintenance of this state is contingent on a spiritual reprieve the likes of which have been touched on in previous sections (Alcoholics Anonymous, 2001). Therefore, regardless of knowledge, experience and personal growth the need for at least some kind of participation in this programme would always be there. Daniel shared these sentiments and was a strong advocate for these programmes.

However, in reality Daniel had actually moved away from this framework quite considerably, although he did maintain a certain level of commitment to this fellowship by attending these support groups once or twice a month. The question itself brought him to a place where he perceived a contradiction in his apparent loyalty to the 12-step program. Simply put, he was afraid because he realised that the change that he experienced in recovery was perhaps more than could be described by the 12-step framework. In a similar vein Edgar openly expressed his need for some level of support in his life, even after 18 years of abstinence and recovery. However, the degree to which he required this was much less now. He said:

> *I've always been involved in 12 steps, so that's been something that I've been doing for 17/18 years. Sometimes more than others. In the beginning I used to go to 5/6 meetings a week and like now I'm doing one a month.*

This quote is very similar to what Daniel had said. The difference could be located in the clarity that he seemed to possess in terms of what he required in his life and his recovery. He was aware of the potential of his underlying pathology but there was no defensiveness or anger in relation to being asked what threatened his life and recovery. However, Edgar was cautious with respect to who he discussed these matters with. He explained that he was, 'past the compulsive disclosure phase', meaning that he did not feel the need to tell everyone that he was an addict unless it was in the service of helping someone else. Although Edgar was very open in his interview he discussed some of the more stigmatising aspects of his disorder. He explained that many people did not view his recovery as something heroic but rather of being indicative of weakness and of being unreliable. He said:

How much do you share how much do you involve people, how much do you trust, and who do you trust? Because some people will take advantage , especially in a work environment, where there is all this competiveness and something like an addictive nature or a struggling with addiction and recovery is not necessarily viewed as strength and it can be bad for your future career, cause you not uh your typical ummm A type alpha male kind of thing.

Inherent in Edgar's statement was a sense of caution regarding potential mixed views related to substance-related disorders. His relationship with the 12-step program provided him with a format to speak about these issues without fear of being judged. However outside of this support group he felt that it was unwise to discuss the true nature of is pathology. The researcher used another example that demonstrated a slightly different dynamic. When asked about the factors that Hanna felt were detrimental to her recovery she said the following:

When I have success, whether it's working for someone or working on my own like I'm doing now, any sort of excessive success, more than I'm expecting tends to push me into a kind of cocky place if you call that and, I've got to watch that, so also I think my gratitude is very much in line cause I found myself grateful, like 20 more times than I used to be.

Hanna described the sense of guilt that she felt about being lazy and not wanting to work sometimes. Being an entrepreneur, Hanna was able to do much of her work from home. However, Hanna saw similarities between her skill as an entrepreneur and her previous behaviour as an addict. In fact she saw her addiction in just about every interaction on a daily basis. There was a deeply self-punishing and masochistic pattern to her behaviour (McWilliams, 1994). When feeling good because she had managed to achieve something materially she immediately felt a deep sense of worry that this temporary success might lead her back to active addiction. Like Daniel, Hanna also feel guilt that she was not taking responsibility for this in the right way as expressed by her continued desire to rationalise her level of participation with her support group.

Thus she explained that she needed to, 'keep herself in line' when she felt like she was doing well in her life. In this instance the practice of gratitude along with many other similar

practices suggested by the 12-step framework seemed to function as a compensatory mechanism that warded off overwhelming feelings (Kelly, Stout & Magil,2011; Johnson, 1999; Frosch & Milkman, 1977). When she was experiencing a negative emotion she would rigorously search for things in her life for which she should be grateful for. The same applied to her when she was left to her own devices. For example, working from home and /or not doing work. For example, a sense of guilt would return when she was relaxing at home. This would provide sufficient a sufficient rationale for her to have to motivate herself to 'tow the line' and get proactive.

Throughout her interview Hanna described her capacity to adopt an arrogant demeanour that she felt was not helpful to her. She explained that without constant awareness around this issue she would regress back into an arrogant person and that this had direct implications for her recovery. She explained that it made her complacent and gave her the sense that she 'could do it alone'. Hanna felt comfortable in describing her capacity for self-destruction but was still very much at a point wherein she required constant care and attention. She did not, however, worry too much about the potential judgments of other people and instead she embraced what was wrong with her and saw in it the opportunity to heal and to grow.

For this reason, she actively practised surrendering parts of her experience that bore any resemblance to previous situations in her life that were related to using substances. It was as though she actively forbade herself from experiencing the feelings and potential behavioural modifications that might result from feeling "too good". Hanna described this state of mind as dangerous and terrifying (White, 2007). The fear of returning to that lifestyle was very real for her. As a result it seemed that Hanna struggled to own her successes. In comparison to what Daniel had said, though, Hanna felt comforted by the fact that she required assistance of her support group and even more so by the fact that she knew what she needed and was able to take responsibility for herself. She valiantly stated:

> *That responsibility is the key word there; the moment I took responsibility, the rest fell into place.*

Hanna derived a huge sense of pride in being able to take care of herself (Krentzman, 2013). This sense extended to both her substance-related disorder and to her bi-polar disorder.

Daniel was also a hugely self-sufficient man but felt uncomfortable at the prospect of knowing that he would always require some kind of therapeutic assistance in his life. Like Hanna, Edgar also demonstrated a healthy acceptance of the fact that he would have to access some form of mental health service and support group for the rest of his life. Many of the other participants felt this way. Notably the participants that felt comfortable with this prospect had in fact attended more forms of therapy than Daniel had. In fact, with the exception of Daniel and Sara all of the participants had attended ongoing therapy for multiple years, especially in the earlier years of their recoveries. Micheal explained:

> *Now that it's a few years down the track, it doesn't feel to me like a badge of honour to me to be wearing.*

Michael's comments indicated that he was less identified with his addiction and consequently the support group that he attended. Micheal had attended in-depth and continued therapy for the past ten years. He had also attended a private rehabilitation centre. In this way, he had explored the destructive potentials that existed within him and was better able to take responsibility for this capacity (Moos & Moos, 2006; Wurmser, 1977). Similarly, the participants that had attended therapy on an ongoing basis, even those with more severe CODs including bi-polar disorder had a greater awareness of the challenges that they were faced with and generally speaking, more accepting of this fact. To further illustrate Micheal said:

> *I do take psychiatric medication and umm I believe that that is something that I should have always have been taking in some way shape or form but it definitely has had a very positive impact on my recovery.*

Before coming into recovery Micheal had been diagnosed with panic disorder and also suffered from depressive episodes for which he still felt the need to medicate. Micheal had attended extensive therapy and felt that it was a necessary part of his life. Through doing so he had a well developed understanding of his underlying problems. Furthermore, he did not feel greatly stigmatised by his disorders but also knew where it was safe and appropriate to discuss such matters.

In conclusion of this section, it was clear that there was a great need to reconcile various experiences in terms of the 12-step framework. It was impossible for the participants not to speak about their relationship with the 12-step fellowship in some way. A point that is worth mentioning is centred around the participants' need to keep their conceptions of recoveries as well as their method to maintain this conception 'uncontaminated'. The researcher felt that this was exemplified by the lack of flexibility in terms of what they viewed as essential to the enhancement of their recoveries. Having said this, those participants that had attended more extensive forms of treatment including regular and ongoing therapy demonstrated a greater interest in discussing different resources that had been helpful to them. It was clear that those who had attended more therapy over the course of their recoveries were better equipped to explore other problems in their lives than those who relied solely on the 12-step program. A final point worth mentioning is that the stigma referred to in this section is primarily discussed in relation to both the participants' awareness of the depth of their challenges as well as the level of acceptance surrounding this reality. To a large extent it appeared that those who had attended more therapy throughout the course of their recoveries were more accepting of these challenges and were thus better able to deal with them in their lives.

4.3.3: Assimilation

This chapter is entitled 'Die Soegenden'. It means the searching people. One of the participants applied the term to people who become addicted. In the context in which it was said, it applied to both the active addiction phase and the recovery phase. This was an interesting twist that later became relevant to understanding some of the patterns that unravelled. Although this section has been placed within the chapter that deals primarily with factors that are harmful to the recovery process, this section should be understood more in terms of one of the fundamental challenges of the recovery process rather than a factor that has only harmful implications for the recovery process.

The accounts provided by the participants, although tragic, also appeared at first glance to be unconscious and simply a consequence of excessive-substance use. The relationship between substance use and the wide range of external consequences is almost too clear. For example, on some levels it would have been reasonable to attribute all the negative

experiences that the participants had experienced to just substance abuse solely. However making attributions like this did not account for the degree and/or extent to which the participants suffered during their substance use.

In the first chapter Micheal explained that he had difficulties tolerating negative emotions and this constituted one of his primary reasons for using substances (Johnson, 1999; Khantzian & Treece, 1977). He was also a cocaine addict. He said:

> *I medicated with narcotics and now I'm medicating with acting out in certain ways, not narcotics but aggression, depression you know, whatever it might be cause I struggle to tolerate that those feelings of discomfort.*

It seemed as though Micheal still wanted to protect himself from uncomfortable feelings. Thus his pattern of self-medication and even his behavioural mechanisms, which he referred to as 'acting out' were essentially, defences against negative feelings (Wurmser, 1977). Micheal also explained how his tendency towards strategies that alleviated negative feelings had persisted even 10 years into his life of recovery. Throughout his life, Micheal had had to deal with his panic disorder and depressive disorder. This is in keeping with research that has indicated that roughly one third of people who meet the diagnostic criteria for alcohol dependence also meet the criteria for an anxiety disorder and research that suggests that at least half of those who seek treatment for substance abuse also meet the diagnostic criteria for a mood disorder (Fabricus et al, 2008).

Michael had been through great lengths to treat his psychiatric problems and as a result was capable of a great many things. He had recently remarried and ran a successful business. Furthermore, Micheal took a great personal interest in understanding both his own illnesses as well as other psychological phenomenon. Michaels' case represents a scenario where in integrated forms of treatment had been sought out and provided. As a result Micheal had attained an unusual level of function for someone who was faced with such severe psychological challenges. Micheal represents some of the potential that is available to those with similar disorders. It is however important to note that Micheal only represents one portion of the COD population as there are many. Micheal would be seen as falling within quadrant two of the four quadrants model. Individuals falling within this quadrant are regarded as suffering from less severe mental illness and as such stand a greater chance of

achieving remission from their substance-related disorder as well as a higher level of functioning (Singer et al, 1999). To re-iterate, Individuals suffering from less severe mental illness co-occurring with substance-dependence quadrant suffer are viewed as suffering from milder forms of mental illness. Such disorders are post-traumatic stress disorder (PTSD), anxiety disorders, less severe mood disorders, eating disorders, attention-deficit disorders and, in adolescents, oppositional defiance disorders (Singer et al, 1999). As individuals in this quadrant usually have a long history of substance abuse, it is common to observe substance-induced psychiatric symptoms (Bruce et al, 2005). These symptoms are not psychotic in nature however, and generally diminish following the cessation of substance use (Singer et al, 1999).

It is important to recognise that due to the hegemony of the disease framework used in substance-related treatment centres; very often the decision to refer clients to either more appropriate or more comprehensive forms of treatment is based not on whether the operation of a mental disorder is present but rather on whether it is severe enough to warrant psychiatric assessment. The decision to treat an individual either psychiatrically or in the substance-related field decision is difficult. However, the decision to commit an individual to psychiatric forms of treatment is commonly accompanied by the client either causing harm to the other clients in the rehabilitation centre, alternatively, when the symptoms of CODs directly interfere with the prescribed treatment schedule. For example, if an individual suffers from severe depression, and as a result is unable to attend group therapy or participate in other important activities, then a decision to refer that individual is possible.

In countries like South Africa where very often, individuals do not have access to the necessary resources to attend any form of psychological services; unless a disorder proves to cause significant dysfunction or harm to oneself or others an official diagnosis may never be made. This is a reality for many developing countries around the world. This trend serves to further supplement 12-step self-help groups as they require no form of payment to attend. Thus important services are delivered between members at no extra expense which makes these SHGs more attractive primarily because they are more accessible.

Edgar provided some interesting insights into what he felt was motivating his desire to continue in his process of recovery. He referred to addicts as, 'Die Soegenden', which as has already been mentioned, means the searching people. This statement led the researcher to reflect on what Edgar meant when he described the perpetual search that recovering addicts enter into once having achieved abstinence. Interpreting this statement at face value brought to mind a picture characterised by an apparent rootlessness wherein these individual were unable to anchor themselves in lives that had meaning. In an attempt to salvage some kind of safety in their lives they required external sources. Previously it could be argued that the lifestyle associated with drug-use in terms of the sense of purpose and meaning, and essentially the effect produced by the substances represented just some of these attempts to find meaning in and make sense of the world around them (Krentzman,2013).

Moving slightly deeper, the researcher considered whether a process of conversion and/or transference had taken place in their recovery processes. Simply stated, in all of the interviews it was determined that the forces and pathology underlying the addictive behaviour still persisted; even after many years of abstinence. To illustrate Sara said:

> *What I was not doing in my active addiction with my energy, I'm now directing it in a very positive way and now because it's addictive energy, I mean I don't think you get away from that thing that you are.*

The researcher found Sara's comments deeply insightful. What she said also contextualised her great need to demonstrate the significance of her achievements. Amongst several other inferences that can be made from what she said, she was actually stating that she could never completely heal from her underlying disorder/s. She believed that it was only ever possible to make modifications to her behaviour and to her internal life but she would never be able to complete change what she was (McWilliams, 1994).

Instead she suggested that she could sublimate the underlying forces and pathology driving her addiction (Watts & Hook, 2009). Therefore, there was still an existing dependence on external things which the participants had learnt to transfer into what they believed were more constructive activities.

Sara felt that it was not possible to completely overcome her addiction in the sense that the certain characteristics that motivated her substance abuse in the first place still persisted. However Sara had learnt to transfer what she referred to as addictive energy into other more constructive activities. In essence all of the participants had learnt how to sublimate what Sara referred to as 'addictive energy' (Watts & Hook, 2009). This dependence was transferred into many different things. Ryan said:

> *I have used a lot of different tools and resources and kind of used everything that was available to me.*

His statement re-iterates the fact that recovery in this context is not a static or uniform process. Instead it is characterised by continuous process of change and adaption. On the one hand, it suggests a process of learning, adaption and evolution. More will be said on this later. On the other hand, it indicates the challenge to find new and healthier forms of dependence. To demonstrate, Dodes. (1990) in his paper on 'addiction, helplessness and narcissistic rage' spoke about the possibility of a transference merger taking place. This transference merger is indicative of a search for an idealised object that the substance can no longer fulfil. This idealised object will through a 'merger' provide an assurance of power and control. This transference can take place in a number of ways. The most obvious example would be a scenario wherein the therapist is perceived to be such a narcissistic idealised object, leading the rapid achievement of abstinence. Similarly the concept of a 'higher power' may also be understood in terms of a search for such an object (Dodes, 1990). Ryan continued:

> *Early days it was all about like my counsellor and my treatment centre you know, and then it became all about NA you know. And then the NA thing changed from becoming a newcomer to doing more service, and then now I think cause certainly the yoga has become more and more a part of it.*

Ryan's comments demonstrate a number of dynamics. Ryan had adopted many focal points for his recovery over the years. These focal points represented developmental points that he needed and utilised at different time periods in his life. As his mental health improved he was able to shift this focus from the 12-step program and the rehabilitation centre that he had attended to things like yoga and exercise. This capacity to internalise the skills and

knowledge that could maintain his recovery was not a quality that was present throughout all of the interviews and will later be discussed (Dodes,1990).

This search for meaning was evident throughout the interview process. It was a processes that persisted into the recovery process and was perhaps amplified by the fact that the participants were no longer debilitated by their substance use and now had excess energy. To illustrate Arthur said:

> *A big issue also linked to this meaning like I was looking for meaning in work.*

Arthur recognised the conflict early on in his recovery. Over the years he managed to resolve his need to over excel and find meaning only in the work place. He saw the negative potential that becoming too pre-occupied with work might have and understood that there was a limit to the pleasure or happiness that he could find in his work. He said

> *Sometimes the meaning is to just get the pay check and that's ok it doesn't have to be idealistic!!!!.*

Arthur had used work to find meaning in his life in the earlier years of his recovery. This shared similarity with some of the accounts from earlier sections that discussed cross addiction. Underlying their narratives from both the first and second chapters was the notion of a lifelong search. The first chapter which dealt primarily with the active-abuse phase contextualised this search for meaning in terms of the self medication hypothesis. The choice of substance that they settled on was not random and was consistently sought out even in a life characterised by chaos and instability (Khantzian, 1949).

Later this search for meaning was evidenced in by the ongoing need for growth and learning that was evident many years into their recoveries. This need was sometimes expressed as a need to excel as was the case with Sara. At other times the journey was more private and was sought through reading books of different varieties. This desire to learn more was also expressed on a physical level wherein some of the participants engaged with activities like yoga and meditation. In any event the search for meaning was evident in their stories right from the very beginning.

In beginning to assess some of the factors that the participants felt were essential in facilitating a life of abstinence there were several ideas that were put forward. Going back

one step, the various accounts both in terms of the multivariate traumas that they underwent and their definitions of recovery, although tragic, also appeared at first glance to be unconscious and simply a consequence of excessive-substance use.

They used substances and did not seem to understand why. In recovery some of the participants wildly adopted a range of interests/focus points etc to help make them feel more secure in their lives. Although the concept of self-medication is spoken about with specific reference to the substance abuse period it was revelatory to witness these participants speak about a similar phenomenon taking place in their normal everyday lives even to this day and even in their present state of recovery. In the interests of presenting a logical sequence of events the researcher wanted to present the active addiction phase examples of self-medication first. This has already been done. The purposes of these next sections is to demonstrate how this trend can and does persist even into the realms of recovery.

Upon closer analysis the researcher realised that this was not true and that this assumption was in fact an oversight. To view their recovery experiences in terms of a reduction in the substance use behaviour would have been over simplistic and did not adequately account for the years of suffering they had previously endured (Wurmser, 1977). It also did not illuminate any of the complex process that seemed to unfurl after they became abstinent.

The participants' experiences before and after actually reflected the fact that throughout their lives, even before they became addicted, the participants addictions' represented a kind of search. This search was evident in their lives for many years but it was only after many years of recovery that the participants were able to identify it as such. In discussing what Edgar had come to believe about the role that substance abuse had played in his life Edgar made some very interesting comments. He said:

> *They talk about at the emptiness, that looking for fulfilment and contentment in all the wrong places as in drugs, alcohol, gambling big womanising, all the quick fixes out there.*

After achieving abstinence Arthur described the presence of a huge thirst for knowledge in his life. For many years he read books and still continues to do so. He had come to believe that his search was not a random phenomenon. The idea of addiction as a search for

meaning can be found in much of the addiction literature as well with other forms of illness in general (Ogden, 2007). Edgar's thoughts were archetypal and classical in the sense that the overtones of his religious orientation were clearly evident in what he said. The combined assumptions of many chief authors suggest a search for something being present in the struggle that people like those afflicted with substance-related disorders are faced with (Krystal, 1977).

It has already been clarified that Arthur actively sought what he referred to as, 'quick fixes' to deal with his underlying problems. These attempts at protecting his self-esteem were not random. This accounted for the active addiction component however it was more complex when viewed from the perspective in recovery. To further clarify; what was of interest was why such a similar phenomenon persists after abstinence is achieved?

When compared with what all of the other participants said in relation to the things that they sought out in an attempt to deal with their underlying problems, an unusual frequency emerged. However the way in which they did this differed greatly. In a group of lives characterised by a burning desire to excel materially and a desperate need for growth and safety some of these reasons become clearer.

It could not be self-medication, as this would actually require the use of substances and although cross addiction seemed to be a reasonable deduction it too seemed over simplistic. Turning to the first manifestations of this phenomenon the researcher looked at some of the comments that Micheal had made. In relation to being asked, "On a daily basis what are some of the things that are most to you"? He said: "on a daily basis I would say that I thrive on acknowledgement and acceptance".

This statement contextualised some of the earlier problems that he had experienced with cross-addiction in the earlier phases of his recovery. He appeared to be fixated at a point in his recovery where he still actively sought significant achievements in his life. Sara's earlier comments shared similarities with what he said. Micheal was an individual who really pushed himself to extremes in his life. It seemed that there were many ways in which he sought this sense of acceptance in his life. One of the areas that this was most clear was the way that he exercised. He said:

I've gotten very close to cross- addiction at times into various forms of exercise, so one of the first things that I did when I got into recovery was I did, I started getting very involved in Bikrum yoga obsessively so, I went five six times a week for years after that was boxing, I was boxing three for times a week and I added running to that and I started getting quite excessive with running.

It was difficult to ascertain whether the phenomenon of cross-addiction was entirely applicable to this scenario. It made sense that in the absence of substances this man sought to adopt other activities that could produce feelings of euphoria but it also appeared to be a form of self-care gone riot(Berczik et al,2011). The need for some activity to make him feel better persists to the present day. Initially, Micheal spoke about exercise being a factor that contributed to his wellbeing. It was primarily connected to taking care of his body unlike in his active addiction wherein he abused his body and his physical appearance. However he was aware at some level that his sometimes excessive patterns of exercise were negative in nature. His tendency to over exercise has improved somewhat over time but he is still very aware that there are negative aspects to this pattern.

Micheal explained that he struggled with self-esteem even after many years of recovery. Initially his exercise routines were an attempt at self-improvement. The importance of routine also cannot be underestimated especially in the early recovery period (Charney et al, 2010). However Micheal took time to mention that his pre-occupation with exercise had persisted even to the present day. He said: "There's always been some focus or obsession around exercise at all costs".

It was not clear whether this was the manifestation of an unresolved issue or if it was simply that Micheal really enjoyed exercise even though he viewed it in some ways as an obsession. What did seem clear was that Michael's need to train at all costs was related to his self-esteem. He said: "I still struggle with self-esteem in a very big way". In a similar vein Martha explained that she had previously cross-addicted to people in relationships that she had had in recovery. She said:

In my recovery I have actually cross-addicted to a person and kind of turned that into a kind of a high low thing. Where if I'm with the person I feel high and if I'm not I feel low.

Martha's comments here also seemed to be very connected to her self esteem and finding ways to make herself feel better. What she said also seemed to be connected to a poor sense of self. At times during her recovery she was unable feel good about herself without being in a relationship or someone to affirm her. She did, however, explain that this pattern of behaviour had improved in her life. These two examples illustrate a form of cross-addiction that can take place outside of active substance abuse. Furthermore, the behaviours connected with these behaviours also took place in a pattern. The actual reasons as to why they were drawn to these patterns of behaviour were generally hidden from the participants, however, their stories confirmed the presence of a phenomenon that in past years and particularly in reference to this thesis seemed very relevant.

The phenomenon was relevant because it illustrated some of the core challenges that the participants had to negotiate in their recoveries. In essence the search that this sub-section seeks to illuminate is about a need to assimilate the properties of the objects and activities that the participants adopted throughout their recoveries (Cockcroft, 2009). The examples that have been used demonstrate that this search is not limited to one thing and can find expression in health concerns, a desire for knowledge and even at the relationship level (Onken et al, 2007).

Earlier on, in the sub-section regarding how these participants understood recovery Arthur was able to distinguish between surface level changes and deeper level changes. The true meaning and joy that he found in recovery had more to do with feelings of self worth and self love than it had to do with material things. For this reason he believed that, "self worth is huge, it is the greatest gift I would say. The greatest change in recovery and self love".

Arthur understood very clearly what cross-addiction was and through immense personal growth had managed to arrive at a point where he felt that the most important things to him was family and being able to care for himself and his family and provide for them to the best of his ability. Although Arthur had gone through periods of cross-addiction in his recovery he no longer felt compelled to adopt external things to make himself feel better to the same extent that participants such as Micheal and Sara did. Edgar had arrived at a similar point although over a much longer period of time. The key challenge that he was now faced with was orientated around assimilating two similar but different frameworks into his life. He said:

I am involved in church now and we going to be helping at the recovery course at Grace Point church starting end of July; it's a sixteen week course combining Christianity and 12 steps. Which you know is exactly what I've been struggling with.

After many years of 12-step recovery Edgar had made a significant move away from the 12-step program to a more religious based lifestyle. Although he still respected the principles of the programme that he had initially used to maintain and strengthen his abstinence he had become much more in involved in Christian religious organisations. Edgar was explaining that he had experienced difficulty in making these two frameworks co-exist. Once having assimilated the core values and principles of the 12-step program Edgar was capable of moving away from the 12-step program to some extent and adopting another spiritual framework. Although these two frameworks shared similarities Edgar still struggled not to feel that he was being forced into a decision of having to choose only one to live by. He said:

I've found judgementalism from all kinds of people is not useful, such as very staunch Christians or such as very strong 12 step people who kind of judge you and make you feel excluded because of certain beliefs.

The challenge for Edgar was finding a way to make both of these belief systems survive and/or co-exist. Thus he had to assimilate sometimes conflicting frameworks with the intention of participating in both of them. Doing this had taken years and was by no means a perfect process. He still felt that committing too much to one of these frameworks led to both feelings of guilt from himself and judgement from people that attended church and others in the 12-step program.

In light of what has been discussed so far it should be clear that addiction recovery and addiction pathology should not always be viewed as discrete entities (McWilliams, 1994). These participants' life experiences greatly differed in degree of pathology and the extent to which their lives were affected by their disorder. The last section suggests that the tools that people use to overcome their substance related problems vary from individual to individual. For example, certain individuals prioritised therapy while other participants prioritised a life characterised by spiritual principles. In any event the need for growth was prevalent.

Thus part of the journey for these participants involved the assimilation of principles from healthy activities that they had participated in since beginning their recoveries. Outside

some of the theoretical concerns of this study what appeared to have happened in the lives of the participants was that the need to understand their underlying problems resulted in positive changes and became in itself a driving force in their recoveries. Through this they engaged in many activities in an attempt to find meaning in their lives and through these activities they unwittingly discovered aspects of themselves that were related to the way in which they felt that they should live their lives.

4.3.4: Concluding remarks and summary of key findings

This study discusses several important dynamics related to the treatment of CODs and substance-related disorders. Many different topics have been discussed in the course of this thesis. The researcher reached far back into the personal experiences of the participants that were interviewed in this study to develop a coherent starting point. The first chapter included a discussion regarding what the participants had to endure prior to receiving help for their disorder/s. It began by exploring the destructive potential of untreated self-medication (Khantzian, 1985). This involved exploring some of the traumas that they experienced while actively abusing substances and the meaning that they imbued to these events. It also explored some of the elements involved in addiction including denial, ambivalence and self-medication as well as how continued abuse of substances lead to breakdowns in multiple areas of functioning. These breakdowns resulted in what was referred to as an estrangement from the self.

The section entitled, “addiction as an estrangement from the self”, described an unraveling process characterised by the inability to know what they were feeling and thinking and a diminished capacity to make sense of these things. It was argued that suffering alone is not sufficient to overcome severe forms of addiction because of a deeply seated ambivalence regarding the substance-related behavior and an incredible level of denial. This state of ambivalence contributed to a walling off of an emotional kind, that prevented the individual

from seeing the true nature of their problems (Krystal, 1977). They were therefore unable to recognise the pattern of self-medication that was underlying their addiction (Khantzian, 1985).

It was found that there was meaning in the suffering that the participants experienced and that this suffering subsequently acted as an essential vehicle of change that led to a radical process of self-enhancement (Chen, 2010). So far it has been argued that the suffering that people who were once addicted endure is not meaningless. Rather it can be viewed as an essential feature of change that allows the once-addicted individual to seek help and to begin on a radical process of self-change (Chen, 2010). It appears that suffering both motivates substance abuse and leads the individual to become addicted. There is thus a bi-directional relationship that exists between suffering and the need for change.

However, it can also be said that much of this suffering was superfluous in the sense that their 'rock-bottom' experiences that were explained in terms of secondary suffering, could have been reached sooner. This is because these rock bottom experiences were subjective experiences. What motivated the change was the realisation of how estranged they had become from themselves and their goals in life through their substance use. Only once they had reached a point of complete self-destruction and profound emotional pain did they find the willingness to seek help.

The next chapter then dealt with the actual point where the participants became abstinent from substances. It was entitled a shift in trajectory to denote those experiences that facilitated an integral shift in the individual's lifestyle. Over the years of their recoveries these individuals adopted different methods of coping to help them deal with underlying problems that seemed to emerge over time. This shift was most obviously characterised by a move to complete abstinence from substances and was motivated by the pain and suffering that the participants had previously endured. The essential and first shift in trajectory, as it was referred to, was constituted by both a private and a public admission regarding the futility of future substance use.

There was also a much deeper set of changes that became evident through discussing the way in which the participants chose to define their recoveries. Some of these changes

included limitlessness in the number of opportunities that were now available to them. An enhanced capacity to deal with stresses in relationships to the extent that many of the participants were able to engage in long-term relationships. Some of the participants had even been married for many years and described happy and functional relationships. The ability to cope better with life's demands was also evident in the way that the participants described their ever developing range of coping strategies. The recovery process was viewed in terms of an evolutionary process that was defined by many different variables. It was a deeply personal experience that did not fit neatly into any traditional or even more contemporary definitions of recovery.

The study then turned towards those factors that facilitate recovery from a substance related disorder. This section considered the way that the participants defined their recoveries. It seemed that doing so provided them with a sense of mastery and further propelled them towards change and self-enhancement. These changes were considered at two levels. There were material gains that represented several important dynamics including the need for agency and security in their lives. These changes were rooted in conceptualisation of recovery as self determination. These developments also lent themselves to an improvement in self-esteem that was characterized by several changes in their work ethic and other areas of their lives. It was argued that a concession to the self and to others was necessary in becoming abstinent. The individual also had to be willing to take steps to recover (White, 2007). The process of secondary suffering provided the potential through which the capacity to access self-caring aspects of oneself became possible (Chen, 2014).

The discussion then turned towards those factors that have a protective quality for the recovery process. These practices varied across the participants but what became clear was that there was a constant need to address their problem and continue to develop in self-awareness as demonstrated by their daily practices such as achieving a sound frame of mind before starting the day. Undertones of the need to empower themselves through daily practices, adopting an alternate social network and preserving the memory of their active addiction phase gave the participants the opportunity to constantly assess their progress and development.

In the final section it was demonstrated that even after many years of recovery some of the participants felt that there was a certain level of stigma associated with their disorders. However, the participant's views diverged in this respect and seemed to be very much related to depth of therapeutic help that they had attained over the years. A second concern for the participants was associated with relationships. Getting involved in dangerous relationships could also sometimes have a very negative impact on their recoveries. Challenges related to re-integrating back into society, as normal individuals, also illustrated a need for supportive structures in their lives and the great level of sensitivity and vulnerability that the participants had in that they constantly needed support in their lives.

Finally, it was shown that one of the fundamental challenges of the recovery process is the assimilation of the properties of objects, behaviours and relationships that they had had in their lives. Some of the participants were able to move away from the 12-step fellowship in significant ways after having spent many years internalising the values and principles that they learnt there(Dodes,1990). The same was true in relationships with a constant desire for growth and learning being present in their stories.

Little is currently known about what types of patients will continue to attend self-help groups in the future and whether 12-step orientated substance-related treatments are an appropriate form of treatment for people with severe CODs. The type of treatment that the participants attended was primarily preventative in nature. Mental health approaches afford several criticisms. Firstly, they assume that people are incapable of caring for themselves and creating solutions to their own problems in living. During the 1960's, the helping professions were conceptualised as the 'frontline soldiers' in an army that would benevolently care for the poor, the retarded and the mentally ill. This conception creates a caricature of the relationship between mental health worker and the recipient of these services with the latter being portrayed as helpless and the former as the all-powerful caregiver (Rappaport, 1987). All of the participants had managed to achieve a state of full recovery. However, the participants that did suffer from severe-CODs including Hanna and Sara required constant care and attention for their disorders in the long term. This suggests that even those individuals suffering from severe co-occurring psychopathology are capable

of deriving some benefits from participation in these self help groups especially in the long term (Bogenschutz, Geppert & Goerge, 2006). All the participants used in this sample had managed to achieve a relatively high level of well being and satisfaction in their lives.

Few studies have been conducted on the notion of recovery itself, and existing ones typically fall short of defining the term. In spite of calls for broader definitions of recovery and treatment outcomes most researchers implicitly define recovery in terms of substance use only (White, 2007). This study clearly demonstrates that the process of recovery is far more dynamic than simply abstinence from substances. Furthermore terms that are typically equated with the term recovery such as remission, resolution, abstinence or recover do not delineate between process and outcome (Ralph, 2007). As long as these disorders remain vague descriptions of pathology that is characterised only by a client having something other than a substance-related disorder, the corresponding treatment that can be offered to these clients will be limited. Thus it is clear that the treatment of clients suffering from multiple disorders is a complex task that requires a specialised level and type of expertise (Fabricus et al, 2008). There are several studies that have explored factors that facilitate recovery from substance-related disorders however there are not many studies that are available regarding factors that are harmful or detrimental to an individual's recovery.

Chapter 5: Limitations and Recommendations for Future Research

Limitations

While the current study explored a new area in the field of CODs and substance-related disorders and went beyond that of previous research that has been done in this field, this study is not without its limitations. There are several limitations that further research could begin to address and that are discussed in the next section.

Firstly the sample consisted of four women and eight men, all of whom were white. Therefore, variables of race could not be discussed in terms of and generalised to the greater population of South Africa. It is very possible that these variables significantly alter the course of action that an individual takes in recovering from CODs. The method of intervention that the participants utilised in order to get well was ultimately preventative in nature. Inherent in a preventative models' mode of delivery are several assumptions that have been overlooked throughout history. In order to deliver skills and services to entire areas, the institutions responsible for the intervention need to assume the existence of a universal set of values and assumptions about what health and illness are. A prime example of this is the disease model. The assumptions of the disease model provide a frame of reference to address problems in life. This framework has proven to be problematic in countries like South Africa where the general population is characterised by multiple modes of understanding the world. For example, many, but not all, African people subscribe to an African cosmological belief system that very broadly views phenomena in living as interrelated. The polar opposite can be said about western ideologies that are fundamentally individualistic in orientation (Mkhize, 2004). Considering that a large amount of statistics are derived from private rehabilitation centres of which the population is largely constituted by white middle-to-upper class individuals the findings of this study cannot be generalised to every person that seeks help for a substance-related disorder.

While there were various commonalities amongst the participants' views regarding certain phenomena there were also significant differences that can be explained in terms of several dimensions. Firstly, not all of participants suffered from CODs and there were therefore limitations between the comparisons that could be made between participants in terms of psychological disorders. The sample used for this study was also derived solely from a

number of 12-step fellowships and so it could not account for the way in which other individuals with substance-related disorders recover. Very often their identification with this self help framework inhibited their responses in the sense that they was an overriding tendency to explain all of the participant's problems in terms of disease or syndrome dynamics. Thus understanding the precise differences that CODs and substance-use disorder populations including co-occurring bipolar disorder, borderline personality disorder personality disorders, mood, anxiety disorders and psychotic disorders and the differences between these populations could not be addressed in this study. Owing to the nature of the sample there was a disproportional focus on the substance-related disorder. It is possible that participants past or current attendance at AA or NA meetings may have influenced them to respond in AA-appropriate fashion (Arnold et al, 2002).

Although it was a pre-requisite to have attended therapy, not all of the participants had attended a private rehabilitation centre. Differences in the amount of treatment that the participants engaged resulted in several differences in what the participants thought was necessary for them to recover. In conjunction the research questions did not explicitly address their notions of what CODs were and it's precise impact on their lives. The interview questions were very open ended and only those who either suffered from severe CODs or alternatively those participants who had attended very extensive therapy had an idea of what the COD phenomenon was about. Thus to make generalisations from this sample without a more comprehensive history of each participant would be inappropriate. Although this was a qualitative study and the sample size was of an adequate size for the research questions under study, in comparison to quantitative measures the sample size was very small and the findings are not be generalisable to larger populations.

Finally the interpretation of the findings was based largely on the objectivity of the researcher. While the participants' experiences were described as accurately as possible, pure objectivity is never possible (Marshal & Rossman, 2011). There are various ways in which objectivity may have been threatened including racial variables, age-related variables and sensitivity in terms of what the participants were being asked to describe in terms of their life experiences.

Recommendations for future research

There are several interesting and important areas that warrant further research. These areas include attaining nationally representative samples of individuals participating in treatment for CODs as this would provide data related to the types and severity of mental and substance use disorders amongst those receiving treatment services. Information in this area would help to meet the needs of future patients suffering from these disorders because it would increase the availability of information on the types of disorders that require tailored interventions and also the frequency with which these disorders occur in treatment populations. Perhaps more intimately connected to this research project would be the possibility of exploring the existing services for those suffering from CODs in terms of staffing, organisation and approaches to integrated treatments as was done to a small degree in this research project (Sacks, 2008).

The participants employed a number of measures to ensure and protect their recoveries. Many of these efforts were preventative in nature. Because prevention efforts assume the existence of universal values in a certain catchment area, very often how such consensus about these values may be reached is ignored. Models such as the disease model offer no theories of social inequality, re-inforcing the notion that the individual acts in isolation (Pretorius & Heuchert, 2001). For example, it is felt that the disease model for treating pathology has certain benefits and as regards long-term recovery rates from both substance-related disorders as well as psychiatric disorders there is still utility in this approach (Bogenshutz, 2007). However, while most bio-medical fields have a relatively clear cut consensual definition of what remission means the drug and alcohol field does not. There have also been few attempts at informing the discussion by people who are 'in recovery'. Consumers of mental health services and other forms social and emotional support continue to tell their personal stories of their struggle with mental illness, the methods they learned to cope with their illness, the barriers they faced and their journeys to wellness.

Based on the data collected in this study, as well as research that has been carried out in this area, there appears to be consensus that there is a need to incorporate specific modifications to this method (Drake, 2008; Kessler, 1996; Flynn & Brown, 2008). These

modifications include creating environments for people who suffer from severe mental illness that are capable of containing and addressing their problems (Drake, 2008). By this it is meant that issues such as stigma connected to the diagnosis of severe mental illness and the inability to relate to the experiences of individuals that suffer only from less severe CODs must be dealt with (Sirey, 2001). Performing a study that includes individuals who have achieved remission through other means such as psychiatric and psychological methods or who have managed spontaneous recovery would add greater depth to understanding the factors that facilitate recovery from CODs.

Another concern is that prevention programmes may not change current social institutions but might add onto them with little evidence that they prevent anything (Rappaport, 1981; 1987; Seedat et al, 1988). Conducting studies that examine the multi-cultural issues of South Africa and the impact of certain ideologies such as the disease model have on people who do not necessarily perceive illness in the same way is worth exploring.

As the term “recovery” increases in popularity, there remains little consensus on what the term actually means. Confusion regarding how to define recovery hinders service development, evaluation and funding policy decisions. Thus if treatment services are expected to foster recovery and researchers seek to evaluate treatment effectiveness in reaching that goal, this goal needs to be explicitly defined. There must be consensus among various stakeholders, policy makers, funding sources, the general public, helping professionals, and clients of services (White, 2007). One of the problems of current definitions of recovery is that research has attempted to provide blanket descriptions of recovery for large populations. Research that further explores what recovery means to individuals suffering from specific CODs would provide helpful information on what is required for these individuals to recover.

Performing research on the differences between different CODs would help practitioners to better understand the risk factors associated with specifically severe mental illness. Problems relating to individuals with severe mental illness has led some to the conclusion that 12-step treatment programmes are not likely to meet the needs of these populations due to issues of funding, organization and staffing. However, these treatment programmes may potentially be able to treat those with less severe mental illness effectively (Sacks et al, 2008; Sterling & Weisner, 2005).

It is also clear that these skills are limited in their availability even in local private rehabilitation centres. This was demonstrated by the fact that many of the participants had to independently seek assistance from psychologists and psychiatrists to assist them in their recoveries. Thus, assessing what measures and tools are most effective in the treatment of these vulnerable populations would prove to be useful and positive areas for future exploration. A study that took factors of differences in perceptions regarding the CODs phenomenon and the ways in which it can be dealt with would provide a bridge between the massive divide that exists between the mental health field and the substance abuse field. This is because the type of integrated treatment approach that is conceptualised as ideal for those suffering from severe mental illness is very difficult to attain in both substance-related treatment settings as well as psychiatric settings. The responsibility for this problem is located within both fields of practice and the resolution can be derived from increased collaboration from these two areas of treatment and expertise (Edwards & Rawson, 2010). For example, it appears that 12-step rehabilitation methods are effective when supplemented by a multidisciplinary task-force including counsellors from different areas of expertise (Bogenshutz, 2005). In conjunction with this, there is an apparent need to view and treat all of the disorders that an individual presents with as primary disorders. This means that the assumption that treating only the substance-related disorder will improve both or multiple outcomes for other disorders must be discarded or modified. Therefore, the trend to attribute all symptomology to substance-related problems is something that needs to be addressed in local private rehabilitation centres (Cherry, 2008).

Finally, research concerning the current success and/or failure rates with clients suffering from severe CODs would be an important area to explore as it would provide important research on the efficacy of treatment methods for people with CODs in the South African context (Cloutier, 2012). In conclusion there is a scarcity of research on co-occurring severe mental illness and substance dependence. It is therefore an area warranting further exploration (Drake et al, 2004; Pettinati et al, 2013).While often these findings cannot be generalised to the entire substance abuse field or the psychiatric field they can provide valuable insights that lay a platform for future research and enquiry.

Finally, the question of whether the point of ‘rock bottom’ could have been reached sooner would be an interesting point of investigation. The rationale here pertains to the fact that

the rock bottom experience was largely subjective. If there are any factors that directly pertain to reaching this point it would be worthwhile conducting research on this area as it could potentially provide insights into how some people who become addicted manage to become abstinent sooner than others.

In conclusion, it is clear that there is not the desired level of awareness of what COD's actually is in substance-related treatment centres as well as in the various support groups that people suffering from CODs attend.

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List of Appendices

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Appendix A: Information Sheet

Good day,

My name is Alistair Heald. I am conducting a piece of my research as part of the requirements for my Masters degree in Psychology at the University of Witswatersrand. My research seeks to understand the way in which you have managed to achieve a state of recovery. This would include an interview**,** the length of which would depend on how much you feel comfortable with disclosing, which would focus on the various obstacles that you have had to go through in your recovery process. The questions will focus on what has been helpful to you on your journey and what it means to you to suffer from a psychiatric disorder/s. It will also focus on the role that 12-step orientated treatments play in the treatment of these disorders and more importantly, the role that these treatments have played in your recovery.

Participation will entail making myself available for an hour long interview which will take place at a neutral venue. Should you agree to participate, I will conduct the interviews myself. With your permission I would like to tape record the interviews to ensure accuracy of the data collected. I will be the only person who listens to the tape and it will be kept in a secure location until the research is complete at which point it will be destroyed. Your identity will be kept secret. That means that nobody except myself will know your identity and that I will not use your name. While the questions do ask you to report and reflect on

your experiences; no personal information that will identify you will be used in the research report. At the end of the study a one-page summary of the results will be made available to participants upon request. I will also write a report that will be available at the Wits University library and parts of this may be published in an academic journal.

Your participation in the study is completely voluntary and you may withdraw from the study at any time without penalty. This includes withdrawing any comments that you may have made during your interview and requesting that your audio recording be destroyed. You may also choose not to answer any question at any point. There are no risks or benefits to participating in the study. No person will be advantaged or disadvantaged in any way for choosing to participate in the study. If you should find yourself distressed you may call any one of the free counselling services listed below. Finally, If you would like to discuss any aspect of this research feel free to contact me.

Please complete the attached consent form if you are willing to take part in this study.

Kind regards,

Mr. Alistair Heald

Tel-076 774 9918

E-mail –coachalistair@gmail.com

Free counselling services:

Lifeline Johannesburg

South African Depression and Anxiety Group.

Supervisor contact details: Dr Malose Langa

e-mail-malose.langa.@wits.ac.za

Number-0735049890

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Appendix B: Participant Consent form (interview)

I_____ have read the attached letter and understand the nature, purpose and procedure of this study, and recognise that participation in the study will not advantage or disadvantage me in any way. I understand that:

- Participation in this study is voluntary
- Confidentiality is guaranteed and that no information that may identify me will be included in this research report and that my responses will remain confidential.
- I may refuse to answer any question I would prefer not to and may withdraw from the study at any time.
- Direct quotations from the interview will be used in the report, but will not be traceable back to me specifically.

Signed_____

Date_____

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Appendix C: Consent form (Recording)

I_____ consent to my interview being tape-recorded. I understand that the contents of the tapes will be transcribed for the purpose of further analysis and that my identity will be protected; access to tapes will be restricted and the tapes will be stored in a secure location. I also understand that the tapes will be destroyed once the research has been published.

Signed_____

Date_____

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Appendix D: Interview schedule

1. Tell me about your life now as compared to your life before your diagnosis?
2. What have been some of the difficulties that you have had to deal with in the years since your diagnosis?
3. What has been helpful to you during this process?
4. Can you tell me about any other factors that have contributed to your well-being and continuing health?
5. On a daily basis, what are some of the things that are most important to you?
6. Tell me about your experience with any health care professionals that you have come into contact with?
7. Tell me about some the things that you have not found useful or detrimental to your process of recovery?
8. Knowing what you know now, what are some of the things that you would have used/done earlier on in your process that you didn't and that have helped you in your process?
9. How has the way that you now look at yourself and the world around you changed since recovering?