Alcoholism - there and back: A qualitiative analysis of interviews with clients engaging with a 12 Step based treatment prgramme.

Hancock, Rebecca Louise

ALCOHOLISM – THERE AND BACK

A qualitative analysis of interviews with clients engaging with a 12 Step based treatment programme.

Rebecca Louise Hancock

Submitted to the University of Wales in fulfillment of the requirements for the Degree of Master of Philosophy.

University of Wales, Swansea

2007

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in canditure for any degree.

Signed ..... (candidate)
Date 29/09/07

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

Other sources are acknowleged by footnotes giving explicit references. A comprehensive reference section is appended.

Signed ..... (candidate)
Date 29/09/07

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be availble for photocopying and for inter-library loan, and for the title and summary to be made available to outside organistations.

Signed ..... (candidate)
Date 29/09/07

ACKNOWLEDGEMENTS

I would like to thank the staff at West Glamorgan Council on Alcohol and Drug Abuse (WGCADA) Limited for their cooperation and support with this research study. In particular, I would like to thank Karen Ozzati and Steve Lewis for their invaluable insight in to the world of alcoholism.

I would like to take this opportunity to wish Professor David Clark all the best for his retirement, and thank him for his initial guidance. I also give thanks to Professor David Benton for stepping in as my supervisor during the latter part of my degree. I am especially grateful for the prompt and constructive feedback he provided.

I would like to express my gratitude to my parents for their patience and words of encouragement which helped to keep me focused. Moreover, I greatly appreciate the financial support they provided which allowed me the opportunity to do this Masters degree. I would also like to thank my brother, Jay, and my sister, Laura, for their support.

Finally, and most importantly, I would like to thank the clients who participated in this study. I feel truly honoured to have been given the opportunity to share their life experiences. I wish them all happy and successful lives as they continue on their journey of recovery.

This thesis is dedicated to my Nan, Marion Mary Higgins (1939 - 2003), her belief in me knew no bounds.

SUMMARY

The contribution of treatment interventions and processes involved in facilitating recovery from addiction are still not entirely clear. In particular, 12 Step research data is notoriously difficult to obtain due to the anonymity of group members and self-selecting nature of the organisation. The present study investigates the processes of recovery from addiction, via a Grounded Theory analysis of semi-structured interviews with fourteen participants, recruited from a 12 Step based treatment programme.

Six major phases, or in Grounded Theory terms categories, emerged from the analysis. In chronological order, these are: the descent into addiction; realisation of the problem [a gradual process]; accessing treatment; the treatment process; spirituality; and recovery. It is suggested that the participants experienced a gradual descent into addiction. As the participants' drinking career developed further, cracks began to show and the telltale signs that appeared indicated a problem with alcohol. Participants appear to have journeyed through a gradual process of realisation of the problem. All participants described a turning point or significant event that prompted them to access treatment. The spiritual nature of the 12 Step programme was self-evident from the data. Finally, participants viewed their recovery as a life-long process, and although they acknowledged that the programme provided them with the tools to achieve and maintain sobriety; they recognised that it was ultimately their responsibility to put these tools into action.

In light of the limited qualitative research on the subject, this study has provided a valuable insight into the processes of recovery via a 12 Step based treatment programme. Working through these process is important for sustaining abstinence and recovery. However, if we are to improve alcohol treatment and rehabilitation services and thus reduce the impact that alcohol use has on the individual's life plus their families/friends, and communities, we need to carry out such research on a larger scale.

CONTENTS

SECTION 1: LITERATURE REVIEW

1.1. The Nature and Extent of the Problem

Alcohol and drug misuse affects individuals, families and communities. The financial cost of substance misuse to the UK encompasses expenditure on health and social care, absence from work, criminal activity, and costs to the criminal justice system. However, the social cost is immeasurable.

Most people who try illicit drugs or drink alcohol do not go on to experience problems. However, for a small but significant proportion this is not the case. As the severity of their substance misuse increases they may develop serious (physical/psychological) problems and deterioration in their social circumstances. They may report difficulties in their personal relationships with family and friends, and face legal and financial problems. Communities are also affected as a result of antisocial behaviour, family breakdown and higher levels of crime.

Continued use of drugs or alcohol can lead to a dependence syndrome or addiction. Jaffe (1980) defined drug addiction as a behavioural pattern of compulsive drug use, characterised by overwhelming involvement with the use of a drug, the securing of it's supply, and a high tendency to relapse after withdrawal.

In a press release in 2006, Alcohol Concern highlighted the burden that problem-drinking places on the UK's economy and society. Alcohol misuse costs the economy £18 billion each year and causes around 22,000 deaths every year. 8.2 million people in England have an alcohol problem, and 1.1 million of them are thought to be dependent on alcohol. Around 1.3 million children are affected by their parents' alcohol problems. Furthermore, the UK Alcohol Treatment Trial (2005) showed that every £1 invested in treating people with alcohol problems saves the public purse £5.

As drug taking is an illicit activity, reliable data on prevalence are hard to obtain. However, the Government's Updated Drug Strategy (2002) states that around 4 million people use at least one illicit drug each year and around 1 million people use at least one of the most dangerous drugs (such as ecstasy, heroin and cocaine) classified as Class A. Many of these individuals will take drugs once, however for about 250,000 problematic drugs users in England and Wales, drugs cause considerable harm to themselves and to others. Drug misuse gives rise to between £10 billion and £18 billion a year in social and economic costs (Government's Updated Drug Strategy, 2002). Singleton et al. (2006) reported that problematic drug users (opiate and/or crack cocaine users) are believed to be responsible for 99% of costs to society of drug misuse (estimated to be around £15.4 billion in 2003/04), 90% of which is drug-related crime. Research shows that quality treatment works and is highly cost effective. For every £1 spent on treatment at least £9.50 is saved in crime and health costs (Godfrey et al., 2004).

1.2. Process of Recovery

McIntosh and McKeganey (2002) stated that we know relatively little about the contribution of treatment interventions in facilitating recovery; what works, for whom and under what circumstances. In order to strengthen the treatment provision available to people with alcohol and/or drug dependencies, it is essential that we endeavour to gain a better understanding of the processes involved when recovery occurs.

One of the most widely cited descriptions of recovery from dependent substance use is the 'maturing out' of addiction theory. Winick (1962) described addiction as a self-limiting process in which addicts 'mature out' of their substance dependency. Based on the police records of heroin addict arrestees in the US, he found that two thirds of addicts 'mature out' of their dependency by their mid-thirties. Other authors have disputed this idea, suggesting that controlled use, imprisonment and death may account for the absence of these individuals from official records (Maddux & Desmond, 1981). According to Winick (1962), 'maturing out' is a process by which addicts abstain from taking substances as the problems for which they originally started taking substances become less salient/significant.

Undoubtedly Winick's (1962) work was fundamental in stimulating a considerable amount of research on the process of recovery, with the majority of research aimed at proving or refuting his thesis (Prins, 1995). In particular, Winick's (1962) work was criticised for failing to provide enough information regarding factors/circumstances under which a process of 'maturing out' would take place. Waldorf (1983), described five routes out of addiction in addition to 'maturing out' of addiction. Waldorf (1983) explained that addicts can also 'drift' out of dependency; become alcoholic or mentally ill; restrain from use as a result of a religious or political transformation; 'retire' by giving up the drug while retaining some aspects of their lifestyle; or change because their situation or environment has changed. Prins (1995) suggested that more qualitative research looking at why and how people get into and out of addiction.

A number of researchers have adopted the idea that recovery from addiction follows a process of stages or phases. The Developmental Mode Model of Recovery (Gorski & Miller, 1984; 1986) proposes that the individual has to establish a succession of developmental goals at various stages of recovery. These stages include a pre-treatment period; stabilisation period; early recovery period; middle recovery period; late recovery period; and maintenance period. The model suggests that individuals vary in their progression through the stages of recovery, and that there is a possibility of relapse. Furthermore, Frykholm (1985) proposed three phases of addiction: (i) experimental; (ii) adaptational; and (iii) compulsive; and three phases of de-addiction, where the process of becoming addicted is reversed. According to Frykholm (1985), the first phase of de-addiction involves a period of ambivalence. The negative effects of drug use are increasingly felt resulting in a gradual desire to stop using drugs; however, this is generally offset by a combination of pleasurable effects of drugs and a physical dependency on drugs. During the treatment phase, attempts to become 'clean' become more persistent, and his/her drug-free periods grow longer. The addict perceives a need for support and assistance and so may seek help. In this phase, the addict undergoes a radical reorientation in which s/he suddenly experiences a desire to fulfil the role of ex-addict. The final phase is referred to as 'emancipatory' when the individual is abstinent and can remain so without external assistance (Frykholm, 1985).

Although Frykholm (1985) has provided a useful model of addiction, it does not provide an explanation for spontaneous recovery from addiction. Other stage-based models, for example Waldorf's (1983) six-stage model, do allow for spontaneous recovery, as recovery is said to occur with or without treatment. In Waldorf's (1983) model, the three phases of becoming addicted are referred to as experimentation, escalation and maintaining. The corresponding three stages of de-addiction are referred to as the dysfunctional or 'going through changes' phase, the recovery phase and the ex-addict phase. In the initial phase, the negative effects of drug use begin to be felt and the addict may make forced or voluntary attempts to stop, which usually results in relapse. Conversely, in the recovery phase, the addict makes a conscious effort to abstain from drugs, and recovery to the ex-addict phase is said to occur regardless of whether the individual receives treatment or not (Waldorf, 1983).

One of the most popular stage models of recovery was developed by Prochaska et al. (1992) who proposed that there are five stages in the process of change, involved in recovery. According to this 'stages of change' model, individuals progress through a series of stages. Initially the individual is not considering changing as s/he perceives that the positive aspects of their substance use outweigh the costs – the individual is said to be in the pre-contemplative stage. Individuals then progress to the contemplative stage, where they become more aware of the costs of their substance use and the benefits of changing but are ambivalent about changing. In the preparation stage, the individual is preparing to take action and may have already made previous attempts at changing the maladaptive behaviour. Subsequently in the action stage, the individual actively attempts to reduce or abstain from drinking and/or using drugs. Finally in the maintenance stage non-using behaviour is consolidated and the individual becomes an ex-addict. According to the model, individuals can move back and forth between stages or even skip stages, which fits in with the notion of addiction as a relapsing disorder. Like the other models, this account is not without criticisms, the primary criticism being whether addictive behaviour does actually involve movement through a series of stages. Nevertheless, it is clear that the 'stages of changes' model has been influential in the development of

various techniques for dealing with addictions, particularly Motivational Interviewing (Miller, 1983; Miller & Rollnick, 1991).

The fact that there are numerous stage/phase models indicates that there is disagreement among researchers as to the number and nature of the stages through which an individual may pass in the course of his/her recovery. However, as McIntosh and McKeganey (2002) point out, there is considerable agreement about the importance of a "turning point" in the individual's drug using career; a point at which the decision to give up drugs is taken and/or consolidated (Prins, 1994; Simpson et al., 1986; Shaffer & Jones, 1989). This turning point is often accompanied by some experience or event which serves to stimulate/trigger the decision (McIntosh & McKeganey, 2002). Researchers have characterised this 'turning point' in various ways. Shaffer & Jones (1989) depict it as an 'epistemological shift'. Contrastingly, Maddaux & Desmond (1980) refer to it as reaching 'rock bottom'. It has been suggested by Bess et al. (1972) that this point is necessary for the recovery process to commence.

Smart (1994) suggests that addicts themselves provide a variety of explanations for cessation. Some researchers have focused on the motivating factors involved, which frequently vary between individual drug users, and may periodically fluctuate within an individual during their attempts to cease using. Negative consequences of drug misuse have been proposed by many researchers as the 'turning point' in a drug addict's life (McIntosh & McKeganey, 2002). It is frequently the accumulation of these consequences, which occur at different points that prompt the addict to acknowledge the need to engage in treatment. In addition to negative consequences, Biernacki (1986) cites 'burning out' as a recurrent reason why addicts bring their drug using days to an end; they become weary of their hectic lifestyle of trying to sustain their habit until they can not tolerate it any more.

Similarly, Frykholm (1985) reported how individuals felt 'tired of the life of a street addict'. Several studies have also shown that the influence of significant others, such as partners or children, can be important in the decision to quit (Waldorf, 1983; Frykholm,

1985; Simpson et al., 1986; Smart, 1994). For example, Simpson et al. (1986) report that more than half of their sample stated 'family responsibilities' were important in their decision to stop, while about a third cited pressure from family members was important. Another significant factor reported to be influential in the decision to abstain is deteriorating health or fear of health problems (Waldorf, 1983; Vallient, 1983; Simpson et al., 1986), as well as the occurrence of more general negative events such as a period in prison or the overdose or death of drug-using friends/associates (Shaffer, 1992; Edwards et al. 1992).

The factors associated with the termination of drug use have been reasonably well studied. However, less research has been conducted on looking at the cognitive processes involved in the decision to stop using. Biernacki (1986) described the process of recovery from dependent drug use in terms of management of a spoiled identity. The decision to stop using comes about when the user's addict identity conflicts with and creates problems for other identities that are unrelated to drug use, such as those of a partner, parent or employee, in ways that are ultimately unacceptable to them. Biernacki (1986) felt that the key to the recovery process lies in the individual coming to an understanding that his/her damaged sense of self has to be restored together with a reawakening of the individual's old identity and/or the establishment of a new one. This approach is in line with the Self Regulation Model of Motivation, which implies that an individual is motivated to achieve an optimal state and therefore, a realisation of an imbalance will stimulate the individual to restore balance (Sussman & Ames, 2001).

According to McIntosh and McKeganey (2002), with the exception of the work of Biernacki and Waldorf (Biernacki, 1986; Waldorf, 1983; Waldorf & Biernacki, 1981), we still no relatively little about the cognitive processes through which the decision is made to stop using drugs occurs. Hence McIntosh and McKeganey (2002) furthered the work of Biernacki and Waldorf on identity, via qualitative research on addiction and recovery, involving semi-structured interviews with seventy ex-addicts.

McIntosh and McKeganey (2002), stated that two central features emerged from their data regarding a successful choice to discontinue using. These included, possessing the motivation to cease using, which is greater than the fear of stopping, and a perception of a future, which is prospectively different from the present. The identity crisis the drug user undergoes provides him/her with both of these responses. This dilemma may be stirred by a variety of occurrences, including either disgust at their current existence, unease at the influence of their behaviour on their significant others, or anxiety related too illness or death. It is the accumulation of events that enlightens the addict about the level s/he has fallen to that usually coincides with his/her 'turning point'. McIntosh and McKeganey (2002) also found that occasionally, the confrontation of a spoiled identity was initiated by one specific incident, such as the threat of loosing a loved one. It was also identified that addicts' are most likely to succeed in their recovery from drug addiction, when their decision to stop using was instigated independently.

McIntosh and McKeganey (2002) believe that one of the problems with stopping for reasons other than self (e.g., to appease a partner) is that the drug is frequently considered more powerful than a whole range of positive reasons for stopping. The only realistic prospect of overcoming this power comes when the drug-using identity is being rejected. Sometimes the addicts' sense of revulsion at what they had become was associated with a belief that they had become a 'different' person during their addiction, although a memory of their former drug-free selves sometimes remained. The presence of this residual memory sometimes played a vital role in the decision to quit, as it enabled addicts to recognise the extent to which their identities had been damaged by their addiction, and provided seeds of hope for the future. Although McIntosh and McKeganey (2002) strongly emphasise the importance of the recognition of a spoiled identity they do not concede that it is sufficient on its own to achieve recovery, rather it was in conjunction with a desire for a new identity and different lifestyle, as well as the need to believe that change was feasible, since without this, any inclination to alter behaviour would simply disappear.

Another important feature of successful recovery revealed by the research of McIntosh and McKeganey (2002) was the attainment of positive reinforcement due to situations that promote abstinence. Relapse was shown to be most probable when these new social links became endangered.

Although much of the relevant research emphasises various aspects in the recovery process, it seems that in order to fully understand the recovery process, one first needs to develop a better appreciation of the nature of addiction and how it develops. McIntosh and McKeganey (2002) began their work by examining the processes of becoming addicted, since they believe that an appreciation of the conditions and circumstances under which participants became addicted, is essential to gaining an understanding of the place of drugs in people lives, and some of the significant issues they had to address in giving up.

In terms of the development of addiction, McIntosh and McKeganey's (2002) findings support previous research, reporting a typical finding of experimentation with softer drugs in early teens followed by a progression to more powerful drugs and regular use in later teens/early twenties. The main reason for participants' initial drug use were curiosity and a desire to comply with the expectations of others, especially peers, although taking drugs in order to cope with problems in their life was also a factor for a small minority. In terms of the progression to regular use, participants offered a combination of explanations/factors influencing this transition including an unconscious 'drift' rather than as a result of a deliberate decision; the influence of relationships or peer groups who provided opportunity and encouragement to use more regularly; boredom resulting from unemployment or poor recreational activities; to cope with life problems and escape from reality; or to overcome feelings of personal inadequacy, such as shyness or lack of confidence. In contrast, participants' escalating use was driven by a continuing desire to experiment and find new 'highs', as well as the need to satisfy ever-rising tolerance thresholds (McIntosh and McKeganey, 2002).

According to McIntosh and McKeganey (2002), recognition by individuals that they were addicted could take anything from a few weeks to several months, depending on the drug being used and the addicts' ability to support their habit. For most of the interviewees, recognition usually came with the experience of withdrawal symptoms and the realisation that they needed drugs to function normally, which often came when they were deprived of them for some reasons, such as lack of money. Occasionally, family/friends would inform the addict that they thought they had a problem, although this tended to be less common than one would expect. It is also clear from the study, that once addicts became dependent their lives became dominated by the need to feed their habit, with the need to obtain money becoming their overriding preoccupation. Often this led to lives involving manipulation and deception of others, and engaging in crime such as theft/shoplifting. Much of the sample also ended up spending a period in prison, and experiencing deterioration in health as a consequence of their drug use.

In terms of recovery, McIntosh and McKeganey (2002) found that alongside cognitive and perceptual shifts, important changes in the pharmacological effects of drugs plays a major part in the addict's decision to stop using. It seems that the realisation that the drug is no longer a positive part of an addict's life represents an important turning point, a view that is backed up by numerous researchers (Stimson & Oppenheimer, 1982; Frykholm, 1985; Prins, 1994). Unlike other literature, the experience of rock bottom-like experiences was not universal or necessary for successful recovery in McIntosh and McKeganey's (2002) study; instead they defined two forms of decision to cease using drugs. These included rock bottom decisions and rational decisions, once again paralleling the work of Biernacki (1986). The main difference between the two types of decisions being having to stop in the former and wanting to stop in the latter. However, both types of choice shared the familiar aspiration to re-establish their identity and prospects for the future.

As is the case in other studies (e.g., Biernacki, 1986; Prins 1994) deciding to give up drugs was surrounded by a great deal of ambivalence for the participants in McIntosh and McKeganey's (2002) sample. There was a clear conflict between a desire to change

and a reluctance to give up the drug. Using the symbolic interactionist literature, McIntosh and McKeganey (2002) suggest that one of the reasons why the process of deciding to give up drugs is a gradual and evolving one is because it involves the individual accepting a negative definition of him/herself. It is believed that this will be resisted for as long as possible, due to the potential implications for the individual's sense of self-worth.

Further important insight into the nature of the recovery process comes from George Valliant, who followed drinkers for forty years. Unlike some, Valliant (1996) does not believe there is a specific age where addicts recover, arguing that the notion of 'burnout' in middle life is a misinterpretation of the relatively smooth attrition among drug-dependent individuals. According to Valliant (1996), the critical factors in achieving abstinence do not seem to be maturation, treatment or even a stable pre-morbid personality or social adjustment, but instead recovery seems to depend on the severity of addiction, and on the individual encountering the right kind of healing experience.

Valliant (1996) argues that there are three general factors contributing to stable remission, which can operate at any stage in the life cycle. The first factor is when there is mild substance misuse, which lasts only for a short period, and a simple change in life circumstances may lead to complete remission. This is illustrated in Robbins' (1993) research in relation to the Vietnam heroin-using cohort – US service veterans who reported dependence while in Vietnam, but reported no problematic use on returning to the US indicating the important role that social context may play in addiction and recovery. The second factor is very severe dependence, which seems paradoxical, but evidence suggests that severity, i.e., getting tired/hitting rock bottom may be favourable for recovery (Valliant, 1996). The third factor is the fortuitous occurrence of life experiences, which disrupts entrenched habits, and minimise relapse. These experiences include acquiring a substitute behaviour that competes with the addiction, encountering compulsory supervision, discovering new sources of hope and self-esteem, and finding new people to love to whom the addict is not 'in debt'. According to Valliant (1996) these experiences are mutually reinforcing circumstances, found most reliably in

Cognitive Behavioural Therapy (CBT) programmes and in self-help groups like Alcoholics Anonymous (AA). Literature reviews of remission from various addictions by Brownell et al. (1986), and Stall and Biernacki (1986) confirm that these life experiences are important.

Similarly the importance of treatment continues to be demonstrated in studies like that of McIntosh and McKeganey (2002), where the interviewees expressed a deep appreciation of various treatment services, such as counselling and support, and detoxification and rehabilitation services. However, since research demonstrates that a range of competently applied treatments with different theoretical underpinnings are likely to give roughly the same kind of success rates, it is somewhat difficult to establish what aspects of treatment are particularly effective. Even though the positive components of treatment remain unclear, it is possible that the common component of the various treatment options may have is the capacity to catalyse and support natural processes of recovery (Edwards, 2000).

Although research suggests that there are people that recover without the need for treatment, there is still a significant proportion who require treatment. Robbins (1993) supports the view that someone who never enters treatment is likely to have a lower severity of problem than someone who does and goes on to say that, "drug users who appear for treatment have special problems that will not be solved just by getting them off drugs" (Robbins, 1993, p.1051).

Edwards (2000) has reviewed relevant research to provide a summary of how people usually overcome an alcohol problem, and some of the ways that treatment can support recovery. Firstly, addicts have to believe that change is feasible, and skilled therapists can be helpful in enhancing self-efficacy. Addicts need to be motivated, and specific treatments such as motivational interviewing can be used here, with much emphasis being placed on the addict being ready to change. Since recovery involves movement towards a goal, therapists can also be helpful in clarifying appropriate and realistic goals. It is clear that successful recovery involves avoiding relapse, which can be done through

learning various psychological skills, e.g., Cognitive-Behavioural Therapy, and with the building of supportive networks, which can be achieved through self-help groups like Alcoholics Anonymous (AA). Finally, since change must be positively reinforced to be maintained, a major part of treatment often involves helping people to find rewarding substitutes for their alcohol/drug use.

Edwards et al. (1997) note that there is great variation between individuals and definitely no one single pathway to recovery, however the increased interest in this area of research has significantly improved our understanding of some of the processes involved in addiction and recovery. Although, with the exception of the McIntosh and McKeganey (2002) study, there seems to be a lack of qualitative research in this field, and therefore it is likely that there is still a considerable amount yet to be discovered and understood about addiction and recovery. The need for further qualitative research is reinforced by Prins (1995) who suggests that a realistic perspective about the course of change that addicts undergo during the course of their addiction needs to explored in detail. Furthermore McIntosh and McKeganey (2002), point out that even though it is commonplace within health and social care services to obtain the views of clients, and to include these views in the planning and delivery of services, this remains a rarity within the substance misuse field. Hence this reinforces the need for more research, which aims to explore the views of addicts regarding their experiences of addiction and recovery.

1.3. The 12 Step movement

The 12 Step movement developed from Alcoholics Anonymous (AA), a self-help organisation founded in 1935 by stock broker Bill Wilson and surgeon Robert Smith (known to AA members as "Bill W" and "Dr Bob"), based on their own experiences of maintaining sobriety through sharing with others. AA is often misunderstood as being a treatment method. AA is in fact a fellowship of peers, connected by their common addiction, which is guided by its 12 Steps (see Appendix 1) and traditions outlining the principles of AA. The only requirement for admission is a desire to stop drinking.

Makela et al. (1996) grouped the 12 Steps into; (i) the decision steps; (ii) the action steps; (iii) the maintenance steps, based on their contents. The decision steps (Steps 1 to 3) involve the recognition of powerlessness over alcohol and a need for help, and a decision to put oneself in the hands of a God of a personal understanding. The action steps (Steps 4 to 9) involve the writing of a moral inventory, sharing that inventory with another person, turning to a God of a personal understanding to remove character defects, and making amends for harm done to other. The maintenance steps (Steps 10 to 12) entail an ongoing and continuous self examination and self correction, a deepening of the relationship with a personal God through prayer and meditation, and the carrying of the AA message to other alcoholics.

While the 12 Steps constitute a set of suggested actions for individual AA member, the "12 Traditions" are organizational principles pertaining to AA as a whole. They define the AA group as the fundamental organizational unit, self-governing in all affairs, self-supporting, declining outside contributions, and non-professional and non-affiliating in kind (Room, 1993).

Alcoholism is viewed as a chronic, progressive illness (or disease) that affects the body, mind and spirit, which can be arrested but not 'cured'. The illness is attributed to a physical 'allergy' that creates uncontrollable cravings coupled with a psychological obsession that keeps finding rationalisations for relapse. The 12 Step programme is designed to arrest the addiction by assisting the person to stay abstinent from all mood altering chemicals (except caffeine & nicotine), one day at a time.

The disease concept gradually evolved over two centuries, and culminated in Jellinek's "*The Disease Concept of Alcoholism*" published in 1960. He concluded that there are five subtypes of problem drinkers. However, Jellinek considered only the 'gamma' and 'delta' sub-types as afflicted by the disease as they are 'addictions' in the pharmacological sense, i.e., an acquired increased tissue tolerance to alcohol, an adaptive cell metabolism, and withdrawal symptoms and craving following an interruption of drinking (i.e., physiological dependence). 'Delta' drinkers have an

inability to abstain because of the occurrence of withdrawal symptoms, however they do not experience "loss of control" when drinking. In contrast, the 'gamma' drinkers are able to abstain after a drinking bout, but experience "loss of control" once they had started drinking. Jellinek concluded that the 'gamma' type of alcoholism produces the greatest damage to interpersonal relationships, to health, and to financial and social standing. This type of alcoholism was described as irreversible and progressive, and complete abstinence was considered as the only path to remission.

There is widespread debate around the notion that addiction is a disease, i.e. that individuals are genetically predisposed and therefore it is not their fault that they have either the predisposition or the illness itself. Williams (2002) explains that the use of the word 'illness' is largely pragmatic; it releases the person from guilt and shame, allowing the person to focus their energy on recovery. Although Williams (2002) acknowledges that it may be argued that the use of an illness model may lead to development of the 'sick' role, she emphasises that the person is seen as responsible, not for the 'illness' itself, but for the consequences of their behaviour and, possibly more importantly, for the decision to change. Furthermore, Rosie B. (2005) explains that todays AA members avoid medical definitions and use the 'disease' description as a way of expressing their feeling of being ill at ease in a world in to which they feel they cannot fit without alcohol.

The 12 Step model states that alcoholism is characterised by -

- Loss of the ability to control (limit) the use of alcohol:

"We alcoholics are men and women who have lost the ability to control our drinking. We know that no real alcoholic ever recovers control."
["Alcoholics Anonymous", 2001, p.30]

- "Denial," or resistance to accept the reality of loss of control over drinking:

"Most of us have been unwilling to admit we were real alcoholics. No person likes to think he is bodily and mentally different from his fellows. Therefore, it

is not surprising that our drinking careers have been characterized by countless vain attempts to prove we could drink like other people."

["Alcoholics Anonymous", 2001, p.30]

The essence of the 12 Step recovery pathway is a changed lifestyle (habits & attitudes) and a gradual spiritual renewal. As Nowinski, Baker and Carroll (1992) indicate, AA has historically emphasized two themes in its program:

- Spirituality – Belief in a "Higher Power," which is defined by the individual and which represents faith and hope for recovery.

- Pragmatism – Belief in doing "whatever works" for the individual, meaning doing whatever it takes in order to avoid taking the first drink.

Newcomers are assisted in their adjustment to the AA through sponsorship by a longer-term member. The sponsor is someone who has achieved ongoing recovery and can therefore serve as a source of practical advice for the client introducing him/her to the concepts and practices of the 12 Step programme. The overall goal of 12 Step programmes is to facilitate clients' active participation in AA meetings allowing the client to meet others who have had similar problems and experiences and can therefore gain understanding and support.

Although its initial focus was on alcohol, the 12 Step model has been extended to include other chemical dependencies, e.g., Narcotics Anonymous, and the treatment of behavioural addictions such as gambling and eating disorders. Family support groups such as Al Anon (for the families of problem drinkers) and Families Anonymous (for families of drug misusers) have also appeared. These self-help groups are highly accessible, are avilable at no cost in most communities throughout the world and, for some substance misuers, may be the only resource ever used to resolve a drinking or drug problem (Room & Greenfield, 1990; and Kaskutas, Weisner & Caetano, 1997).

1.3.1. The Minnesota Model

In the 1940s and 1950s three centres in Minnesota were established that incorporated the AA philosophy: Pioneer House, Hazelden Foundation, and the Wilmer State Hospital. These centres developed an integrated treatment programme that was an adaptation of the 12 Step programme. The Wilmer State Hospital programme was particularly influential due to the pioneering work of Dr Nelson Bradley and Dr Daniel Anderson. A highly structured program was developed, set in the context of a patient-centred social learning environment, combining medical treatment, multidisciplinary teamwork, individual counselling, group work and a therapeutic community environment. Medical staff and psychologists worked alongside clergy and lay counsellors (who were themselves recovering alcoholics).

Developed and implemented over a period of three years, mostly from 1952 to 1955, the programme became known first as the Willmar Model. The Model spread to the Hazelden Foundation (founded in 1949, located in Centre City, Minnesota and directed by a not-for profit Board of Trustees led by Patrick Butler, who was himself a recovering alcoholic) in the 1960s where it became known as the Hazelden Model, and finally in the 1970s, as it gained wider acceptance, it became known as the Minnesota Model (Anderson, McGovern & DuPont, 1999).

Anderson et al. (1999) highlight the key elements of the model: (1) the integration of professional staff with trained recovering alcoholics; (2) the focus on the disease concept and link to the 12 Step fellowships; (3) the dedication to family involvement; (4) the insistence on abstinence from the use of all addictive drugs; (5) the emphasis on patient and family education; (6) an individualised treatment plan; and (7) a continuum of care integrating sustained aftercare into all treatment plan. However, the most important attributes of the programme, according to Anderson et al. (1999), were the following two characteristics: i.) the programme was firmly rooted in a profound respect for individual, unique alcoholic people and their families; and ii.) the commitment to the idea that it was possible, with the help of a Higher Power and the fellowship of AA, to get better.

In Minnesota Model treatment circles there is widespread belief in a multi-factorial model, i.e., people are genetically predisposed to increased risk, with some being more predisposed by aspects such as personality, environment, social circumstances, development, learning and conditioning.

Initially, the Minnesota Model was used in a 28-day inpatient setting. However, the Minnesota Model has evolved to include outpatient care. WGCADA (West Glamorgan Council on Alcohol and Drug Abuse) is an example of an outpatient Treatment Centre that has adopted the Minnesota Model of addiction.

1.3.2. Effectiveness of 12 Step programmes

Research data in relation to AA has historically been notoriously difficult to obtain (Bebbington, 1976). Although 12 Step is appearing more often in contemporary literature, methodological challenges still remain, the main difficulties being the anonymity of group members and self-selecting nature of the organisations (Williams, 2002). However, a considerable body of evidence in the alcoholism field indicates that earlier engagement in 12 Step self-help groups, more frequent meeting attendance, involvement in a greater number of 12 Step activities (e.g., acquiring a sponsor) and a longer duration of participation are all associated with subsequent reductions in drinking and better overall outcomes across time (Kelly, 2003; McKellar et al., 2003; Morgenstern et al., 1997; Moos & Moos 2006; Kaskutas et al., 2005; Emrich et al., 1993; Ouimette et al. 1998; and Project MATCH Research Group, 1997).

The 12 Step Facilitation Therapy (TSF) was found to be equal in effectiveness to Cognitive Behavioural Therapy (CBT) and Motivational Enhancement Therapy (MET) in the Project MATCH study of drinking outcomes (Project MATCH research group, 1997). This study involved the random assignment of more than 1,700 alcohol dependent clients to one of the above therapy groups.

Carroll et al. (1998) compared individually delivered TSF, CBT and an individual Clinical Management (CM) condition, either with or without adjunctive disulfiram, in

the treatment of individuals dependent on both cocaine and alcohol. Self-help involvement during treatment was significantly higher for patients assigned to TSF compared to those assigned to CBT or to CM. Furthermore, the mean total of days of self-help attendance during the 1-year follow-up was higher for participants who had been assigned to TSF compared with participants assigned to CM or CBT, but no significantly so. Both TSF and CBT were associated with significant reductions in alcohol and cocaine use over the course of the 12-week treatment programme compared to CM; the substance use outcomes for TSF and CBT were comparable and not different from one another. However, at the 1-year follow the differences between CM and either the TSF or CBT were no longer significant; and TSF and CBT had comparable outcomes (Carroll et al., 2000).

Donovan and Wells (2007) reviewed evidence supporting 12 Step approaches with stimulant misusers. They concluded that the combined effects of being involved in a treatment approach that emphasised 12 Step involvement plus actual engagement in self-help activities was associated with the best outcomes, better that those found with either of these alone. Furthermore, increased 12 Step meeting attendance and/or involvement appear to lead to a decrease in subsequent substance use among stimulant misusers.

Stinchfield and Owen (1998) presented outcome results for 1,083 males and females admitted to a private residential alcohol and drug abuse treatment centre. The treatment was based on the Minnesota Model approach. Data collection occurred at admission to treatment and at 1-month, 6-month, and 12-month post-treatment. At 1-year follow-up, 53% reported that they remained abstinent during the year following treatment and an additional 35% had reduced their alcohol and drug use.

In one Finnish study, a "Hazelden-type" of treatment was compared to a more traditional social-psychiatric inpatient treatment (Keso & Salaspuro, 1990). While no between-groups differences in alcohol consumption were observed at the 2, 4, 6 and 8-month follow-ups, the proportion of abstinent patients was significantly higher in the Hazelden-type group during 8 to 12 months.

Cook (1988) reviewed a number of studies showing the Minnesota Model to be effective in drug and alcohol dependence but points out that many studies have weaknesses particularly in regard to a lack of control groups for comparison.

1.4. West Glamorgan Council on Alcohol and Drug Abuse: The Treatment Model

The voluntary sector treatment agency WGCADA (West Glamorgan Council on Alcohol and Drug Abuse) was founded in 1979. It provides outpatient treatment for people with alcohol and drug misuse problems.

WGCADA's Primary treatment programme is based on the Minnesota Model of addiction. Hence addiction is viewed as a medical disease, which can be treated with one-to-one counseling, family therapy, group therapy and involvement in 12 Step self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

WGCADA's treatment model also uses Reality Therapy, a cognitive behavioural approach to therapy, which was developed in the 1960's by Dr William Glasser. This type of therapy involves a method of counseling which enables people to make more effective choices and direct their own lives. It also empowers people to develop the strength to handle the stresses and problems of life. The core idea behind Reality Therapy is that we are not prisoners of our pasts. In other words, regardless of what has happened in our lives, or what we have done in the past, we can choose behaviours, by understanding our thought processes that will help us meet our needs more effectively in the future.

1.4.1. Treatment Goals and Objectives

Clients may "graduate" to the Primary treatment from WGCADA's Pre-treatment programme. This programme involves two phases: (i) Phase 1 which lasts eleven weeks and primarily aims to educate the individual about substance misuse and addiction, and (ii) Phase 2 which lasts approximately eight weeks and determines the individual's commitment to the abstinence programme. During this phase the individual accepts they

have a chemical dependency. However, if the client is deemed ready for Primary treatment they could access the programme directly without having to attended the agency's Pre-treatment programme first.

People usually complete the Primary treatment programme in nine months to a year, however this can vary depending on the individual. Clients accessing the programme have one full structured day at the agency a week, which includes group therapy, didactic lectures and educational activities. Clients also see their designated counsellor once a week on a one-to-one basis providing an opportunity for reviewing progress and addressing issues that might be too sensitive to be dealt with routinely in a group setting. WGCADA expect their clients to attend three self-help meetings every week and to read the "Big Book" (i.e., the Basic Text Alcoholics Anonymous book which was first published in 1939) as well as other AA publications throughout the course of treatment.

When a client comes into the primary treatment the first few sessions look at the advantage of getting into recovery on an abstinence basis. This enables the counsellor to gauge the client's interest in voluntarily committing to the 12 Step programme. Clients become aware that their drinking and/or their using, has proved to be an ineffective behaviour because it is not getting them what they want. The counsellor then works with the client to determine the clients' short- and long-term objectives.

WGCADA's Primary treatment programme consists of five phases that correspond with the first five Steps of AA. Although the programme is structured, it ensures that the client's treatment goals and objectives are individualised within the parameters of the five phases. Phase One deals with Denial by the recognition of a substance dependency, acceptance of unmanageability of one's life and recognition of dishonesty with self and others. This phase involves a significant amount of written work exploring the concept of powerlessness and the negative consequences of the substance-related behaviour. During this phase, the client completes a life story which is later shared with their group members who in turn provide feedback on what they have heard.

During Phase two, which is referred to as the Phase of Hope, areas covered include: a recognition of the need to change behaviours and attitudes, and a recognition of the ability to do so with the help of others, a Higher Power and the programme.

Phase three looks at the issue of trust. From the assessment the client has done in Step 1 (regarding powerlessness and unmanageability), and from the recognition of the fact that change is possible from Step 2, the client moves on to making the decision to take responsibility for his/her life. The client becomes willing to change the things that can be changed, and accepting of the things that cannot. During Step 3 the client learns to let go of their need to control.

Phase four requires a full written inventory of specific personal character deficits and assets relating to past behaviour. In this Step, the client continues with the work begun in Step 1, only at a deeper level. Any characteristics that may have led the client to use alcohol and/or drugs to change the way they feel about themselves are examined. In this Step the client is helped to deal with guilt and shame by owning all the unpleasantness that has gone with substance-related behaviour. Step 4 is not only designed to help the person get in touch with the behaviour or emotional patterns but with a value system.

Phase five involves a personal in-depth interview to explore with another person deficits relating to past behaviour and assets relating to current behaviour. In this Step the client continues with the assessment that has begun during Step 4 by sharing it with another human being. The client is better able to identify behavioural and emotional patterns and value systems by receiving input from another person. This feedback leads to a better understanding of the events that have occurred in the client's life and the need for positive behaviour changes in order to establish a responsible life style.

1.4.2. Aftercare Programme

WGCADA's aftercare programme involves monthly group therapy and one-to-one counselling sessions. During the aftercare programme, clients work through Steps 6 to 12 of Alcoholics Anonymous, and also deals with any early recovery issues that may

arise. The programme strengthens and supports the gains made by the clients. Active participation is expected in the self-help groups such as AA and NA such participation is recommended to be lifelong.

1.5. Aim of study

Stinchfield and Owen (1998) stated that the Minnesota Model has consistently yielded satisfactory outcome results, and suggested that future research needs to focus in the therapeutic process of this treatment approach. The overall aim of the present study was to conduct qualitative research investigating the process of recovery from alcoholism via a 12 Step based treatment programme. It is hoped that a detailed analysis of client interviews will help to identify factors that are important in achieving abstinence, allowing recovery to be maintained in the longer term, and in potentially allowing an eventual exit from addiction. The research was exploratory in nature, as it was hoped that by collating detailed reports from recovering alcoholics, important issues would emerge that would help to provide a clearer insight into individuals' experience of addiction, recovery and treatment. It is intended that the outcome of this study will contribute to the understanding of the psychological aspects of addiction and recovery, have clear implications for treatment and rehabilitation practice, and reduce the impact alcohol use has on the alcoholic's life, plus those of their families and communities.

According to Smith (2001), qualitative research provides the researcher with an opportunity to capture the richness of emerging themes rather than reducing participants' responses to quantitative categories. Furthermore, Smith (2001) describes the 'natural fit' that exists between qualitative research and semi-structured interviews, since this method allows more flexibility than conventional structured interviews, such as surveys and questionnaires.

The interview material was analysed using the approach of Grounded Theory (Glaser & Strauss, 1967), which allowed a conceptual framework to emerge from the data. This approach is different from other methods in the sense that it allows the generation of theory that closely approximates the reality it represents, rather than the testing of

theory. The inductive nature of this method assumes an openness and flexibility of approach, which is advantageous since it allows the researcher to follow the leads gained from the data (Charmaz, 2001).

The individuals in the study were either accesing the treatment programme (and therefore clean from all mood altering chemicals), or recovering addicts who had completed the treatment programme, and continued to use the aftercare service available from the treatment agency. Hence, participants referred to past events which had influenced the development of their addiction and their path to recovery, as well as commenting on the treatment they were currently receiving. Obviously such retrospective data has potential difficulties associated with it, such as the problem of recall and the possibility that events and circumstances might be reinterpreted or presented in ways that suit the individual current perspective/perception of self (McIntosh & McKeganey, 2002). Although it is obviously important to bear in mind any potential biases, as McIntosh and McKeganey (2002) point out, the alternative of following a cohort of alcoholics was not viable due to the length of time it would have taken, the associated expense, and difficulties of following up clients.

SECTION 2: GROUNDED THEORY

The methodology of the present study is based upon the technique of Grounded Theory, a qualitative analysis that has been developed in sociology over the past 40 years. It was initially developed in 1967 by Glaser and Strauss. The technique is essentially a "bottom-up" approach to the conceptual analysis of semi or unstructured qualitative data (Pidgeon et al. 1991).

Grounded theory was chosen for the current study over other methods of qualitative analysis, such Interpretative Phenomenological Analysis (IPA, developed by Smith, 1995, 1996) for example, as the aim was to investigate the process of recovery from alcohol addiction via a 12 Step community based treatment programme. IPA, on the other hand, would have been used if the aim of the study was to gain insight in to individual participants' psychological worlds and explore their personal perception or account of their experience as opposed to attempting to identify an objective account of the phenomena.

Furthermore, Grounded Theory's specific approach to theory development was viewed as appropriate for this study. Generally, grounded theorists start with general research questions as opposed to a tightly framed pre-conceived hypothesis. Unlike most other research methods, Grounded Theory merges the process of data collection and analysis. The researcher collects initial data, explores the data through open coding, establishes tentative linkages between categories, and then returns to the field to collect further data (Glaser & Strauss, 1967). Hence, theoretical development turns on theoretical sampling (Charmaz, 1983; Glaser, 1978; Glaser & Strauss, 1967).

Theoretical sampling allows the researcher to sample incidents that may challenge or elaborate emerging theory (Willig, 2001). The researcher may gather more data, ask more questions, and check their developing categories. This process enables the researcher to follow up interests, leads and hunches that they find or identify in the data, and it also allows the researcher to check, fill out, and expand theoretical categories

(Charmaz, 1990).

The aim of the movement back and forth between data collection and analysis is theoretical saturation, i.e., the researcher continues to sample and code data until no new categories can be identified, as well as for following up unexpected findings. In addition, data collection is also shaped by the analytic processes of coding, memo-making, integrating and writing the developing theory (Charmaz, 1983; Glaser, 1978; Glaser & Strauss, 1967).

When developing formal theory and refining the original analysis, constant comparative methods are initiated (Glaser & Strauss, 1967). By identifting similarities and differences between emerging categories, constant comparative analysis ensures that the researcher links and integrates categories in such way that all instances of variation are captured by the emerging theory (Willig, 2001). Hence the conceptual power, depth and comprehensiveness is enhanced.

SECTION 3: METHOD

3.1. Ethical Approval

An Ethical Committee Application was completed in line with the British Psychological Society Ethical Guidelines. This Application was submitted to the Psychology Department Ethical Committee for approval. Once the Committee had sanctioned the research (see Appendix 2), an alcohol and drug treatment agency was contacted regarding participating in the study.

3.2 Recruitment of Participants

The alcohol and drug treatment agency informed clients about the study and requested volunteers. No incentive was offered to participants during recruitment. The treatment agency facilitated the organisation of the interviews and all interviews took place at the treatment agency.

3.3. Sample

The sample contained fourteen participants, all of whom were recovering from an alcohol addiction. Nine of the participants were male (average age 38.22 years, range 25 – 51 years old) and five were female (average age 42 years, range 28 – 51 years old). The average age of the participant sample was 39.57 years (range 25 – 51 years old).

Nine participants were at varying stages of the Primary treatment abstinence programme (3 were on Step 1; 1 was on Step 2; 3 were on Step 3; and 2 were on Step 5). The remaining five participants were in recovery and using the aftercare service offered by the treatment agency.

All of the participants described alcohol as being their primary problem. However one participant had also used heroin; and two participants described poly substance use.

3.4. Interview Schedule

Before the interview commenced, participants were read a standardized description of the purpose of the research (see Appendix 3), and they were assured of confidentiality and anonymity. Participants were also informed that they were under no obligation to answer any questions that they were uncomfortable with, and that they were free to pause for a break or terminate the interview at any time. Each participant was then asked to sign and date a standardized consent form (see Appendix 4).

A qualitative design, using semi-structured interviews was adopted (see Appendix 5). The interviews explored the way in which participants viewed their addiction and recovery, and the potential role of treatment within recovery. After each interview was completed the participant was thanked for their time and co-operation.

3.5. Data Analysis

The interviews were recorded using an Olympus DSS Player 2000. The interview recordings, which ranged from 22 minutes to 1 hour 42 minutes, were subsequently transcribed verbatim onto Microsoft Word. A Grounded Theory[1] approach was used to analyse the data, which allowed for the emergence of concepts from the interview data (Glaser & Strauss, 1967).

3.5.1. Quality Control

Elliot et al. (1999) outlined seven guidelines for publication of qualitative research studies which are highly respected within psychology and related fields. An overview has been provided to demonstrate how the researcher has endeavoured to meet these guidelines to ensure better quality control regarding the analysis of the data:

1. *Owning one's perspective* – The author was working as a Research Assistant within the substance misuse field when she embarked on this study. Hence she had prior knowledge of different treatment interventions/programmes. At a later

[1] Grounded theory is designed to facliitate the process of 'discovey', or theory generation when analysing qualitative data.This approach was first published by Glaser and Strauss (1967).

date, the author secured employment with the treatment agency that the participants were sampled from; however she was not employed to work within the abstinence model. Instead her role was more in line with the harm reduction ethos. Whilst the author advocates the role of harm reduction, she believes that abstinence is an appropriate goal for addicts.

2. *Situating the sample* – The sample contained nine males (average age 38.22 years, range 25 – 51 years old) and five females (average age 42 years, range 28 – 51 years old). Ten of the participants described themselves as White British; one as White Scottish; and one as White Irish. At the time of the interviews twelve participants were unemployed and the two remaining participants were employed.

3. *Grounding in examples* – Examples of the data have been used throughout the results section to illustrate the fit between the data and the researchers' understanding of it.

4. *Providing credibility checks* – The researcher reflected responses back to the participants during the interviews to check that the meaning of the account had been understood. Furthermore a colleague with extensive experience in the substance misuse field looked over the analysis and supporting data, and suggested some corrections and elaborations to the original analysis.

5. *Coherence* – To prevent ambiguity, the categories that emerged from the data have been presented in separate sections, with each section beginning with a series of bullet-points representing the concepts (and subcategories if appropriate) contained within the overall category. Then following a brief explanation of the overall category, there is a more detailed interpretation of the data, where each of the concepts and sub-categories are explored more thoroughly.

6. *Accomplishing general vs. specific research tasks* – The author has warned against generalising the results to all recovering alcoholics as the study contained a small sample of fourteen participants from a specific treatment programme.

7. *Resonating with readers* – The analysis is substantiated by extracts from the client interviews in an effort to bring the subject matter to life. The data is presented in such a way to demonstrate that the results are "grounded" in the data.

SECTION 4: RESULTS

A number of significant categories emerged from the Grounded Theory analysis of the data. Each category comprises of a number of concepts, and in some cases these concepts have been grouped together into subcategories pertaining to the overall category. To prevent ambiguity the categories are presented in separate sections, with each section beginning with a series of bullet-points representing the concepts (and subcategories if appropriate) contained within the overall category. Then following a brief explanation of the overall category, there is a more detailed interpretation of the data, where each of the concepts and sub-categories are explored more thoroughly. This analysis is substantiated by extracts from the client interviews. The extracts have been anonymised by using the code relating to the participant's transcript plus the relevant page number of the excerpt.

The analysis focuses on the following six main phases (i.e., categories) which materialised from the data:

- Descent in to addiction
- Realisation of the problem [a gradual process]
- Accessing treatment
- The treatment process
- Spirituality
- Recovery

4.1. Descent into addiction

- Positive reinforcement (of alcohol use)
- Drinking differently to peers
- Increased alcohol consumption
- Perceived control
- Concealed drinking

Participants described a gradual descent in to addiction. Initially, alcohol use was used on a recreational basis however it gradually became more frequent and the amount consumed became greater.

Reminiscing about their early encounters with alcohol, participants recalled enjoyable experiences.

> ... I loved it [alcohol]. I loved drinking. I loved everything that came with it.
>
> [B2- 2, page 2]

Positive reinforcements of their alcohol use, e.g, self-confidence and the feeling of well-being, continued as their alcohol using career progressed. Participants described how alcohol provided an anaesthetic effect for the psychological unease they felt.

> Alcohol had been my prop all my life ... I didn't have close friends, I was very shy and this shyness is still with me today but it made problems for me because I couldn't relate to my peers at the time and that went through my school life.
>
> [B2-3, page 1]

When reflecting on their drinking, participants' stated that they *drank differently to their peers*:

> Looking back I always seemed to want an extra one or two drinks... once I had a drink I always had to have another one. I had a particular friend at

> the time, we'd meet up and go out for two pints and he'd be quite happy to go home then, get ready for work but I'd always want another one.
>
> [B2-3, page 1]

Increased alcohol consumption by participants appears to have been a gradual unconscious 'drift' rather than a deliberate decision. In the following quote the participant is describing how her alcohol consumption increased. Ironically she justifies buying larger bottles of vodka in terms of financial savings despite the fact that she ended up drinking more:

> ...it [alcohol use] just gradually progressed. I thought, 'Well why buy a quarter bottle when a half bottle is much cheaper although I know I won't drink all that.' So of course I was drinking a half bottle! 'Now why buy a half bottle when a whole bottle is so much cheaper but of course I won't drink all that.' But of course I did... I don't know if I was kidding myself by buying the bigger bottles, telling myself it was cheaper... it is a classic sign of an alcoholic – kidding themselves.... [gradually] I drank more and more and more, and it got earlier in the day also... so it definitely was a gradual process, it crept up.
>
> [B2-1, page2]

Although the participants described a gradual increase in their alcohol use, they recalled that they still felt in control of it. For some, this *perceived control* was linked to their ability to abstain from alcohol for periods of time and participants' perception of a stereotypical alcoholic. For example, in the following quote the participant states that she did not feel that she was an alcoholic because she did not drink first thing in the morning as she perceived an alcoholic would:

> ... at the time I wasn't drinking in the morning and I was stopping drinking at 6 – 7 o'clock when we had our evening meal and so to me I felt that I wasn't an alcoholic, well it took me many, many years to come to terms that I was an alcoholic... like I said I felt in control and it didn't particularly worry me.
>
> [B2-1, page 1]

For all the participants there came a time when they *concealed the amount that they were drinking* from their loved ones and friends:

> I thought I was invisible. No-one knew what I was getting up to. No-one knew the states I was getting in… though it was pretty damn obvious.
>
> [B2-6, page 5]

4.2. Realisation of the problem [a gradual process]

- Loss of control
  - Preoccupation/Obsession
  - Compulsions
- Negative consequences of alcohol use
- Delay in accepting the problem
  - Positive reinforcement (of alcohol use)
  - Negative reinforcement (of alcohol use)
  - Excuses/justification
  - Denial
- Gradual acceptance of problem
  - Emotional and/or physical pain (withdrawal)
  - Unsuccessful attempts at reducing/relapses
  - Alcohol needed to function
- Exhaustion – Hopelessness & Desperation
- Dislike of self

As the participants' drinking career developed further, the cracks began to show and the telltale signs that appeared indicated a problem with alcohol. Participants appeared to have journeyed through *a gradual process of realisation [of the problem].*

Due to their persistent use of alcohol, participants experienced an increase in their tolerance levels and alcohol craving. They described a *loss of control* over their alcohol use which was evidenced by their *preoccupation/obsession* with alcohol and the *compulsions* they felt to drink.

> … the mental obsession was there all the time because my mind was always away in places that I could feel comfortable…seedy pubs and

> bars. Because that is where I did feel comfortable, it was part of an escape from the real world really. What I would describe as cravings, certainly if I had had the first drink, certainly I would need the next one...
>
> [B2-10, page 3]

> After my alcoholic poisoning episodes... on the third or fourth time I stopped drinking for 8 days. Every single minute of the day, that's all I thought about was drink. My will wasn't enough, after 8 days I thought, 'Oh I'll have a shandy' and then the next day it was one pint of Guinness and then a whiskey and then the next day it was, 'Fuck it, let's get a bottle!' and then I was back.
>
> [B2-3, page 7]

> It got to a stage where I was drinking like every day. Every waking moment you know? It was the first thing on my mind... I'd drink anything I could get my hands on, it just didn't matter.
>
> [B2-4, page 1]

In the following quote a participant describes how unexpectedly alcohol took control of her:

> ***How did you feel at that point when you realised "Yeah actually, I do have a problem with alcohol"?***
> It's really frightening because I like to be in control and it was just frightening that I had started to drink more to help me control my life because I felt unhappy about a number of things and somehow having a drink made me feel more in control of my life and suddenly the drinking itself, the thing that I'd sought to help me sort my life out was actually taking me out of control.
>
> [B2-5, page 1]

Inevitably as alcohol became a priority for the participants, *negative consequences* followed. These negative consequences varied from losing a job or home, neglect of self, physical and/or psychological deterioration, breakdown of relationships and/or involvement with the criminal justice service.

> I was basically on the streets, you know, and in a bad way really suffering from alcoholism – not washing, not eating, not anything, just totally in a mess.
>
> [B2-4, page 5]

> ... I remember my first blackout, I woke up in a police station and I couldn't remember anything from the night before, I didn't know why I was there! Even after I'd been released from the police station I went home and went to bed and woke up and thought, 'Oh it was just a dream, I wasn't there!'. Everything was just so hazy, but I had been there. That was the first time I ever got arrested... Drunk and Incapable, I was found crawling up the road, so you know if they hadn't taken me in anything could've happened to me...
>
> [B2-12, page 1 &2]

During the interviews, recounting the devastating effect that alcohol had on their relationships with family members and significant others appeared to provoke the most emotion among the participants.

> ...I couldn't make friendships, I couldn't hold on to relationships, I couldn't work, I couldn't eat properly, I couldn't sleep properly. It was every single part of my life was damaged by it. My son, you know, I couldn't look after my son. I wrecked my marriage. I had no real relationship with my parents. My brothers and sister wouldn't talk to me... The only friendships I could make were other addicts who were using... it [alcohol] was completely devastating. It just really ruined my life.
>
> [B2- 6, page 2]

> ... my parents didn't know whether I was dead or alive, my closest friends who I grew up with didn't know whether I was dead or alive – they'd had enough of me! My daughter hadn't seen me for months. All I had was a carrier bag with clothes and a pair of shoes...
>
> [B2-8, page 1]

> I don't think I appreciated the enormity of what I'd done to my wife because it's only in recovery that I've appreciated how my behaviour has been frightening and really intimidating to her. I was totally unaware.
>
> [B2-3, page 2]

As the participants' drinking increased and they experienced more negative consequences as a result of their alcohol use, they began to acknowledge that something was amiss although there was a significant time delay before they accepted the severity of the problem:

At what point did you recognise you had a problem with alcohol?
.... about 15 years ago it slowly began to dawn on me although I didn't accept it for a long time...

[B2-1, page 1]

This *delay in accepting the problem* appears to have been enhanced by the *positive and negative reinforcement* participants' experienced when they consumed alcohol. Participants explained how even though they were experiencing negative consequences through their alcohol use; "good times" were still being had which made them reluctant to accept that they had an alcohol problem.

At what point did you think, 'I've got a problem with alcohol'?
... if I look back, and I'm doing a lot of work around this now, I can see that there were signs even going back to '97 – '98... I had a little niggling in the back of mind in '97 – '98. It was niggling but it wasn't constant – there were good times.

[B2-13, page 1 & 2]

In the below quote, the participant is explaining how initially her alcohol use seemed to have a positive effect on how she felt and furthermore it seemed to improve her relationship with her husband:

The first time that I had a quarter bottle of vodka on my own during the day it made me feel great and I was happy and I had a smile on my face when my partner came home from work, and he was pleased and I thought, 'Oh this is good! This feels good... It's taken away the drudge of the day. It's making me happy and smiley when my partner comes home which pleases him so therefore this is a good thing.'

[B2 – 1, pages 1 & 2]

Negative reinforcement also played a role in participants' continued alcohol use:

Do we want to do something about it when it's blocking out so much? You know its hiding all the emotions and things that we don't want to feel.

[B2-14, page 5]

> I had started to drink more to help me control my life because I felt unhappy about a number of things and somehow having a drink made me feel more in control of my life
>
> [B2-5, page 1]

Participants explained how they used to make *excuses* to themselves and others to *justify* their continued alcohol use:

> ... it's [alcohol problem] been there for years but I'd always use excuses, I used to work so it was like, 'Well I can't sort myself out cos I've gotta work' you know? All these excuses which to me at the time seemed totally valid but they were just ways of justifying for me to carry on doing what I was doing... I think even though you know [there is an alcohol problem] you don't accept it.
>
> [B2-12, page 7]

Denial also played a part in the delay participants described in accepting that they had an alcohol problem. This denial was reinforced again by "good times" still being had:

> ... the denial was so rife in me it kept me saying, 'You're just out to have a good time. You're not out to harm no one'.
>
> [B2-8, page 1]

There were times when participants felt psychologically and/or physically that they could go no lower; however they bounced back and soon that lowest point became a distant memory. This further enhanced participants' denial that alcohol was problem:

> I've hit rock bottoms before but they were what I would call 'trampoline' rock bottoms – I bounced back from them in the space of like two months, they were bad but they weren't that bad.
>
> [B2- 2, page 11]

Although participants were able to recognise that something was wrong, they did not accept that alcohol was the main problem.

> It's a bit like waiting in the dentist surgery, you're not too sure what's going to happen... you know what it could be and your fingers are crossed that they are going to say that there is nothing wrong.
>
> [B2-7, page 4]

> Eventually I contacted WGCADA after the second doctor gave me the number. I still thought I had some other illness besides drinking too much. I couldn't admit that it was solely alcohol...
>
> [B2-3, page 3 & 4]

Participants *gradually came to accept* that they had an alcohol problem.

> I think probably four or five years before I detox-ed I knew I had a problem but I was ignoring it and I was telling myself that I wasn't a daily drinker and that it wasn't large in quantity. And I suppose three or four years before I detox-ed I recognised that it wasn't just that I had to have a drink everyday, it was that I had to have more and more each day.
>
> [B2-5, page 1]

This gradual acceptance of the problem was enhanced by the *emotional and/or physical pain (withdrawal)* participants experienced. For example, in the following quotes the participants' talk about how towards the end of their drinking the emotional pain became unbearable:

> ... in the end it became so painful emotionally, not so much physically... It was just the pain up there in my head...
>
> [B2-2, page 1]

> The end of my drinking wasn't the worst amount that I had drunk, it was just emotionally the worse I had felt... I just remember vividly, standing in [a nightclub] with my friends and looking at them all and feeling almost outside myself is the way I can explain it. And looking at them and thinking, 'I just can't do this anymore.' Something that night broke. My heart broke is the way I always explain it. I looked at them and I just walked out leaving them all behind... My heart had to break cos financial and family losses meant nothing to me. When my heart broke that was the turning point...
>
> [B2-6, pages 18 & 19]

For other participants the emotional pain was bearable; it was the physical effect that alcohol was having on their life forced them to seek help:

> ... I was totally enslaved. I knew I should stop drinking but there was no way that I could – I couldn't think of seeking help at that time. It wasn't 'til my physical sickness through alcohol – [that] made me go to the doctor. I was totally ignorant of where drink was going to take me, all my life.
>
> [B2-3, page 8]

All of the participants recalled *unsuccessful attempts* at trying to reduce/control their alcohol consumption.

> I had lots of failed attempts at starting to reduce personally, you know, before I sought help and I would do that without telling anyone and then I would really feel completely a failure so I'd drink more!
>
> [B2-5, page 1]

All of the participants explained how eventually they *needed alcohol to function* and their alcohol use became daily.

> ... it was just a vicious circle everyday - the shakes, the dry retching in the morning so you'd have to have a few drinks every morning to sort yourself out, to just basically function. Then of course once I had had the first drink – that would get the ball rolling again. And I would be in the same position the following day.
>
> [B2-7, page 1]

> I used to go to work drunk ... I would function, I wouldn't be falling around the place but I'd have to keep myself at a certain level to function... sometimes I'd take a quarter bottle of whiskey (to work) in my pocket... I couldn't function without a drink. I had to have so much (alcohol) in my system...
>
> [B2-3, page 3]

This daily routine led participants to feel *exhausted.* They described a sense of hopelessness and desperation. One participant summed this feeling up when he referred to himself as a "totally broken person" (B2-3, page 4). Participants felt unable to cope

without alcohol and furthermore, due to their previous unsuccessful attempts at trying to reduce/control their alcohol use, they knew they could not give it up alone.

> It got to the stage where I was stuck in a rut and I wanted to get out of it but I just didn't know where out was. I just believed that this was the way it was and that that was the way it was gonna end basically... die of an alcoholic death.
>
> [B2-4, page 1]

> ... what alcohol promised me at the beginning all those years ago was that I would be happy... but over the years it did totally the reverse you know in the end it made me angry. For a while it kept me comfortably numb you know stopped me from feelings... in the end I came crashing down to earth with a big bang, collapsed in a heap – my body and my mind was broken you know I was totally burnt out... I couldn't see a way out of it. In the last two years, I used to drink to die... cos I was too much of a coward to top myself, I thought drink would help me finish it off...
>
> [B2-8, page 1]

> I had enough. I'd had enough. Didn't want to live anymore but didn't want to die.
>
> [B2-14, page 1]

Participants frequently referred to how alcohol made them feel like a different person. The negative consequences they experienced as a result of their alcohol use often led to them having feelings of guilt and shame. They described how they *disliked the person they had become*:

> ... I became very violent on drink. I wasn't a nice person... alcohol would just turn me in to a totally different person... I'd have no recollection of what I'd done which is quite sad really. I'd wake up the next day and nobody would be talking to me and I couldn't remember or it'd all be vague you know?
>
> [B2-12, page 1 & 2]

4.3. Accessing Treatment

- **Turning point/Significant event**
- **Readiness**

- **Contacting the treatment agency**
- **Necessity for treatment**

All of the participants described a *turning point or significant event* that prompted them to *access treatment* for their alcohol use. Although participants mentioned events such as a relationship break up or being caught drink driving, ultimately their decision to access treatment was driven by them feeling unable to carry on with their lifestyle.

> I can remember being in a park on a Sunday morning...I just had to get out of the house, and I had bought a bottle, and I was literally sitting on the park bench and I suppose it was this decision time. And I really couldn't face going back through it all again. And I knew if I drank it would sort the problem for that hour but as they say it would just bring it all back on. And I just poured it away. Came home, told my wife and we had a long chat and I just phoned WGCADA...
>
> [B2-7, page 2]

The participant from the above quote continued by explaining it was the realisation that he had become something that he did not want to be that prompted him to make a decision about his alcohol use:

> Sitting on that park bench and I was the thing that I didn't want to become... although I was one - the bum on the park bench... It was just that I happened to be tidily dressed. I wasn't smelling; I was clean shaved and all of that stuff. I had the house, I had the income but I was still the bum on a park bench... I think I knew I was an alcoholic for a long, long time. I don't think that I had admitted it to myself... I think I did on that Sunday morning... as I was tipping the bottle out, I had to tip the bottle out - if I had have thrown it in the water I'd have been back for it, I knew that... And I think by tipping it out I think the compulsion just went as it went out...
>
> [B2-7, page 5]

The concept of *readiness* was paramount to the participants accessing help for the alcohol problem.

Why do you think this time has been different to previous attempts?
Total and utter surrender I think. I reached the jumping off point and I knew that if I didn't come in to recovery that I was going to die and I just gave in, completely gave in. This illness had beaten me and I wasn't putting up a fight anymore... I just wanted recovery more than anything else in the world and I had to want it more than I wanted another drink, that was the factor – the scales were tipped.

[B2- 9, page 13]

In the following quote the participant explains quite simply why his previous attempts at addressing his alcohol misuse failed:

I wasn't ready, it was as simple as that. I still had to do some research!

[B2- 9, page 2]

There was a general consensus among the participants regarding the importance of *accessing treatment* for themselves rather than, for example, trying to hold on to their partner when the relationship was breaking down or to please their family:

Why do you feel this attempted at treatment has been different to your previous attempts?
I'd just had enough. I really had had enough. I tried getting sorted for my parents, I tried for my daughter, I tried for everybody else but never tried for me and it got to a point where I had to try for myself. I'd had enough. I was slipping so far down the scale and I couldn't see a way back up you know? I was suicidal everyday. I'd drink and then I'd have a hit [of heroin] which in itself was dangerous and then I'd take Valium. I was just mixing so many things hoping that I would just go to sleep and that I wouldn't wake up but it didn't happen! ... I'd just had enough. I wasn't functioning as a human being, everything revolved around the drink and the drugs... it was just ridiculous! It was like, 'I've got to get out of this!'... I was either going to end up in prison or dead...

[B2-12, page 7]

Participants explained how their decision to *contact the treatment agency* was influenced by the positive changes they saw in other people who were in recovery:

... I knew people who had gone through the treatment programme here and I knew it had helped so I decided to come back to [the area] and do it.

[B2-12, page 1]

> I didn't know if I wanted to be clean and sober for a while but all these people in the [AA] meetings had something that I wanted you know? I could see that they were happy and that they could smile without having a drink... and how wonderful their life is. I wanted that wonderful life. I didn't know whether I wanted to stay sober or not but I wanted what they had and I kept coming back for that...
>
> [B2-8, page 6]

Twelve of the fourteen participants stated that they felt that *treatment was a necessity* for them:

> I know for sure, one hundred percent that I couldn't have done it without this [treatment] Centre. I couldn't have.
>
> [B2-1, page 3]

The remaining two participants felt that they could have achieved the same level of success in Alcoholics Anonymous (AA) however they felt the process would have taken longer:

> ... in AA alone I'd probably be where I am today but it would've taken me twice as long unless I had a hell of a sponsor...
>
> [B2-3, page 8]

The main benefit of accessing treatment in addition to attending AA meetings appears to be the in-depth work on self that participants undergo during treatment:

> ***Do you think you could have done this in AA alone?***
> No never. I had to look at myself. It wasn't enough for me to just put the drink down. I had to look at myself and what was making me unhappy...
>
> [B2-14, page 3]

> AA obviously put me on the right tracks and I know people who have gone to AA and never taken another drink. For me it wasn't enough I don't think. I needed to find out about myself – sort of what made me tick.
>
> [B2-7, page 5]

In the below quote, a participant is explaining why she felt she needed to access the treatment programme although she had been sober for some time:

I'd never done any Step work. Nothing about me had really changed - my behaviour, my attitude, my thinking hadn't changed at all. The only thing was that I wasn't getting off my head every day.

[B2-12, page 3]

4.4. The Treatment Process

- **Disease concept**
  - **Non acceptance**
  - **Process of realisation**
  - **Acceptance**
  - **One day at a time**
- **Laying the foundation for recovery**
  - **Acceptance of being powerless**
  - **Unmanageability and damage caused**
  - **Externalising thought and feelings**
  - **Hope for a new life**
- **Group therapy/Counselling**
  - **Controlled environment/Confidentiality**
  - **Sharing of experiences & Identification**
  - **Trust and Honesty**
  - **Acceptance/Belonging**
  - **Confrontation/"Tough Love"**
  - **Exposing blind spots/Peer feedback**
  - **Client-Counsellor relationship**
- **The role of Alcoholics Anonymous**
  - **A Lifeline**
  - **Sharing of experiences and identification**
  - **Acceptance/Belonging**
  - **Flexibility (due to different times and places of meetings)**
  - **Integrated approach (Treatment programme and AA programme)**
  - **Strength and growth**

In order to understand the process of change individuals undergo through recovery, *treatment* needs to be considered. Specific to this particular treatment programme is *the disease concept* which states that alcoholism is a chronic, progressive, and potentially fatal disease. Furthermore this disease can be arrested (by abstaining completely from alcohol) but not cured, i.e., an alcoholic will not be able to drink moderately like a non-alcoholic, for any sustained period. Essentially the disease concept views alcoholism as a health problem (a physical and emotional disease) rather than a question of willpower.

For some participants the initial *non-acceptance* of the disease philosophy appeared to be because if they accepted it then they were accepting that the only cure would be to abstain:

> ***How did you feel when the 'disease concept' was introduced to you?***
> ... What kicked in was this is a progressive illness, it gets gradually worse... And I could see it getting worse... This is what's going on with me, I understand now but I still wanna drink but I've come to the point where I can't because I'm going to go insane or I'm gonna die...
> [B2-2, page 13 &14]

> ***Why weren't you able to accept [the disease concept]?***
> I thought it was just the problems around me, bad relationships and things, and, 'If only I could get out of this relationship, I would stop drinking. I'm sure I could just go to the pub and have a couple and come home,' you know?... I just didn't want to accept it...
> [B2-11, page 3]

Other participants explained how the disease concept gave them a license to drink:

> I thought it [the disease concept] gave me a license to drink. I thought, 'Well if anybody confronts me about it, I'll tell them I've got a disease!' [laughs] For me it was like an enabling then so I certainly didn't challenge it at all.
> [B2- 9, page 6]

One out of the five participants in the aftercare sample explained how initially she had found the disease concept hard to accept as she viewed it as a "cop out", and she felt

uncomfortable about not taking responsibility for her actions especially where her family were concerned:

> ***How did you feel when the disease concept was introduced to you?***
> [I felt] that's giving me a cop out to say that I have a disease and therefore I have no responsibility... And I thought, 'Oh gosh I can imagine me going home and telling my husband, "Well, you know, none of this is my fault - I have a disease!" I just thought, 'No, it's a cop out!'
> [B2-5, page 6]

However, she continued by explaining that the more she looked at her past behaviour, the more she could understand why she had behaved in that way when put in the context of the disease concept:

> ... the more I thought about it, the more I thought, 'I can understand this!' I began to see how in my own life that that could have been the case. You know, why should I after my brain haemorrhage have one glass of wine in a lovely hotel bar meaning that to be the only drink and within 2 or 3 days I was drinking as much as I'd ever drunk before, you know? A normal person doesn't do that and I didn't do that because I wanted to. It's this awful psychological and physical addiction, and I thought, 'Yeah I do believe this.'
> [B2-5, page 6]

This *process of realisation* was shared with other participants as they reflected on their past behaviour. Participants also explained how recounting previous relapses after periods of abstinence helped them to accept the disease concept, as they appeared to have no control over their alcohol use. Furthermore, hearing about other people's relapses assisted with participants' acceptance of the disease concept.

> Two people have died that were in recovery when I first came in. They couldn't accept they had a disease, couldn't accept one day at a time, couldn't accept that they were an alcoholic and they drunk themselves to death...
> [B2-8, page3]

Participants described experiencing a sense of relief when they accepted the disease concept as they finally had some answers to why they behaved the way they did:

... it was an answer to it, the answer to why because it's extremely puzzling why some people can be alcoholics and some people can't. And how insidiously, you know, it grabbed me and dragged me down. I didn't understand that.

[B1-2, page 5]

I'm glad I know what I've got so that I can deal with it... If I had diabetes I'd want to know that I had diabetes so that I could do something about it... I have to keep reminding myself everyday of what I am, even if I'm sober.

[B2- 9, page 6]

... I do recognise that I have a manifestation of an allergy around alcohol so that helps you know not just having no control over it but I'm allergic to it... that's the frame of mind that I have around alcohol. I don't flinch if it's in the same room as me like a hot flame or anything but I know if I drink the stuff I will have a severe allergic reaction to it...

[B2- 9, page 7]

Acceptance of the disease concept allowed participants to deal with the guilt they felt around their drinking and the way they had behaved:

... knowing that there wasn't really anything I could have done about it... It was something that was out of my control. It was gonna happen, presumably whatever. Whether certain things have pushed me over the edge into that chasm or whatever, I've got no control over those. The same chasm is there for everybody else it's just that when I fell in it as opposed to somebody else falling in it, you know, they got out and I didn't for whatever reason. I think it does make it easier that you are not totally blaming yourself then... I didn't really want to do any of the bad things that I did. I didn't want to do any of the damage that I did. If you'd asked me when I was sober... I didn't want to do that. But I did do them but not intentionally. So it does help to take a lot of the guilt away.

[B2-7, page 7 & 8]

Did you ever challenge the disease concept?
No, no I embraced it with open arms thinking, 'Thank God, I'm not to blame.' I needed some answers.

[B2-1, page 3]

> ... drink isn't the problem and I suppose in a way drugs aren't the problem, it's me that's the problem. I didn't intend to come out an alcoholic... it's obviously something in me that makes me different from yourself say. I can't blame any traumas in my life cos thousands and millions of people have lost their dad, got divorced, had this, had that. So I can't blame any of that, it's just that I've got this little thing inside me, whether it's part of a gene or whether it is something else...
>
> [B2-7, page 2 &3]

Participants explained how their acceptance of the disease concept was eased by practising the *"One day at a time"* AA principle:

> I don't look at it as [I'll never be able to drink] again, it's one day at a time... Just don't drink for today.
>
> [B2-4, page 5]

> I don't know what is going to happen tomorrow...I'd like to think that I am never going back down there but I don't know. Day at a time...I mean I could walk out of here and get hit over by a bus!
>
> [B2-7, page 2]

Participants talked about how the *foundation for their recovery* was laid during Step 1, i.e., *"We admitted we were powerless over alcohol – that our lives had become unmanageable"*.

> ***Why was Step 1 so important?***
> Because it's the basis for everything. From that first Step comes everything else. You can't do any of the others without that.
>
> [B2-1, page 7]

> Everybody says it's the basis – it's the foundation... he [a person in the fellowship] sort of sees the 12 Steps as – the foundation is Step 1 and you build your house with Step 2 and Step 3 and that's the bathroom and that's the... you can always come back and knock down the bedroom and rebuild it. But if you've got a good foundation, no matter what you do afterwards, you can always start again to build that bit. If you've got a rock bottom then it is solid. And I thought yeah... I'll get my foundations okay and I might have a leaky bedroom but I can always adjust it. I haven't got to go back and dig the foundations up again.
>
> [B2-7, pages 12 & 13]

> Step 1 is the foundation of recovery and if you don't do a good Step 1 and you go on to other Steps it'll be like the leaning tower of Pisa...
>
> [B2-8, page 5]

7 of the participants had completed treatment at the time of the interviews. When asked what, if any, Step had been the most important for their recovery, the general consensus was that Step 1 was the most significant and also the most emotionally painful Step.

Pertinent to this Step is participants' acceptance that they cannot control their use of alcohol (and other drugs) hence the driving force of their life, i.e., the addiction, is beyond their control and they are therefore powerless over it.

All of the participants described a gradual process of *accepting that they are powerless* over alcohol. Some participants explained that it was only after failed attempts at "controlled drinking" where they had unsuccessfully tried and tested their power over alcohol that they gave in.

> When I was first in treatment I had doubts around Step 1 that's why I kept going back out there you know? I thought, 'Am I really powerless over this?' If there's a shadow of a doubt then my recovery would go down the pan... I think before I came back here I knew that I was powerless, absolutely powerless...
>
> [B2-9, pages 6 & 7]

Step 1 also deals with the person's *unmanageability and the damage that their addiction has caused.* One participant, who had been away to residential treatment, decided to access the treatment agency as she recognised that she needed to do Step work. Even though she had been abstinent for nineteen months she felt that nothing had changed apart from the fact that she was abstinent:

> I felt very nervous [starting treatment] cos one thing that I'd never dealt with, always said I was fine with, was all the stuff around my using, all the things that I'd done when I was using and drinking, and I was like, 'No I'm alright with that. It wasn't me.' and that was enough for me to say that. Then having to go on to Step 1 you know and have a look at all these examples of my powerlessness and my damage around it all was

> quite difficult because I'd been clean and sober for so long. I thought, 'I don't need to look at that' but I did need to look at it because it's that that reminds me how much damage I can cause if I pick up a drink...
>
> [B2-12, page 5]

The participants explained how they began to see the unmanageability of their lives by reviewing their drinking history.

> It was an incredible amount of work, an incredible amount of going back in to your experiences and looking at, in the beginning, your unmanageability. Looking at your inability to stop, you know, looking at examples of that. It was very much about digging and finding out... and I found that very painful...
>
> [B2-5, page 5]

> [Step 1] involved having to deal with looking at the reality of the outcome of my drinking career over the years. All the damage and the unmanageability - in all sorts of ways... to other people, to myself, mentally and emotionally and physically, because all of those things were affected in varying degrees... looking back I can see it now - it [alcohol use] was always out of control. And the unmanageability then...life becomes unmanageable – all the problems and of course the twist of the mind that says that the drinking is because of the problems and not the other way around – not the problem's because of the drinking. So there's dealing and looking at all of that...
>
> [B2-10, pages 9 & 10]

Participants explained how the process of exploring the damage that their addiction had caused others, acted as a reminder for what would happen if they begun drinking again.

> Because we do tend to forget the things we've done to hurt other people and that's brought to the first and foremost of your mind. So if you think about a drink you know it's in the front of your mind, how you're gonna effect other people... it is the reminder of it, it does stop you having a drink.
>
> [B2-11, page 5]

Participants talked about how externalising their thoughts/feelings by doing the preparation work for, and completing their life-story on Step 1 allowed them to deal with

the feelings around the damage their drinking caused not only to themselves but also to their significant others:

> ... I'm writing about family at the moment and unmanageability... I could go on for reams and reams of paper... I'm one of those that says the next day after something's happened, 'Oh forget it! It's a new day!' put it in the cave and I've forgotten it! But I've actually found when I write things down, piecing things together or actually look at behaviour over a period of time I actually do remember it, it's just that I haven't dealt with it or thought about it. So seeing it written in black and white, sometimes it's brings up some feelings you know?
>
> [B2-13, page 4]

> I really had to look deep in to myself and all the written work, there was a hell of a lot of written work... it was difficult really searching in to yourself and finding all those times when you really damaged someone because that's what the work is about. It's about the damage you've done to other people and being an alcoholic, I block that out and also being an arrogant bastard as well! And I've also got a feeling of superiority in me so that arrogance and superiority I had to batter that down to accept the fact alcohol had me beat.
>
> [B2-1, page 7]

Externalising their thoughts/feelings was seen as part of the healing process. As one participant who was on Step 3 at the time of the interview reminisced about the six months she spent on Step 1:

> It was really emotional but it was really good. I mean I used to share things, I used to go home and I used to feel crap and I used to cry but it was really good to stop me picking up that first drink – seeing what I was when I picked up a drink and realising that it's not me you know it's me in a drink but it's not who I'm supposed to be. But it was really hard work and the life-story was great, a huge chunk of recovery that was – I'm glad it's over! [laughs]
>
> [B2-14, page 4]

Although participants generally described a gradual process of change as they proceeded through treatment, participants stated that they started to really notice changes in themselves during the preparation and completion of their life story:

> ... doing my life story changed me to be quite honest actually looking at things from a different perspective. All the years I'd spent thinking, 'How wrong I'd been done' but actually looking at it and knowing my part in things as well you know? That was a big change for me. That was something that I found very hard to do, I was very much a victim and I played the victim role brilliantly but when I did my life story it changed my perspective of things because when I actually looked at certain incidents in my life you know a lot of the time I had a part to play in them as well and it wasn't solely out to get me and there were some things that I had no part in which were unfortunate but other things I had a part to play in them. I sort of played out these roles... and created all these situations for myself and that was an eye opener for me and that brought about a big change really by looking at things in a different way... my head isn't as hectic as it was, slowly things are slowing down for me...
>
> [B2-12, pages 11 & 12]

A female participant from the aftercare sample remembers how she struggled with working through issues from the past. However by working through her personal powerlessness and unmanageability, it also gave her hope that you can progress from Step 1 and learn how to get the power back in her life:

> I think that Step 1 was good for me... it was actually recognising my unmanageability and seeing it for what it was, and realising that I couldn't manage my own life and I was powerless over alcohol. I think I'd known that but I hadn't actually looked at in the sort of context which Step 1 gave me. And seeing Step 1 as the start, that you then moved on to look at how actually you could get power back in to your life - it would help you to deal with it. It wasn't just wallowing in defeat which is what I had done for so long.
>
> [B2-5, page 7]

This *hope for a new life* was shared by the other participants as they realised that change was possible:

> .... realising that it's not me you know it's me in a drink but it's not who I'm supposed to be."
>
> [B2-14, page 3]

The treatment programme consists of *group therapy* and *one-to-one counselling*. When participants were asked about how they felt sharing personal information in a group

setting they stated the process was helped by the *controlled environment* and level of assured *confidentiality*:

> You can talk about anything and I know it's confidential... there are things I would say in WGCADA that I would not say in an AA meeting...
>
> [B2-7, page 9]

The *sharing of experiences and identification* among the group appears to be enhanced by the *trust* among the group members which allowed them to speak openly and honestly about their drinking and the consequences of their past behaviour:

> ... we were able to talk openly, honestly and freely without fear of retribution. You're in a safe environment with people that you come to know and they come to know me...
>
> [B2-1, page 14]

Participants talked about how the sharing of experiences in the group setting makes *honesty* contagious.

> Actually sharing examples in a group situation well that was quite scary you know, thinking, 'What are these people going to think of me? They're going to think I'm awful!' but that's what gets us sober and keeps us sober... the level of honesty spreads I found. If I heard somebody giving a very frank and obviously painful share then I would be inclined to do the same you know... They've risked with me, I'll do the same with them. I think that's how the group works – the honesty spreads throughout the group, it's a knock on effect and of course the more honest you can be the better...
>
> [B2-9, page 7]

Due to the honesty of the shares and identification participants described feelings of *acceptance and belonging* – feelings that they had longed for, for some time:

> I've started talking about how passionate I feel about certain things and I never used to talk about that. And I used to think that I was scaring them away and putting them off, and they were like 'No, that's more attractive' you know? I used to be called a twat for talking about this stuff... I had

never been able to talk about stuff like that. That's what I have always struggled with, really deep down.

[B2- 6, pages 12 & 13]

Participants acknowledged the need for *confrontation*, also referred to in AA as *"Tough Love"*, as an important tool in the treatment process to help them change their thinking and behaviour.

What is it about this treatment programme that suited you?
... I liked its confrontational nature – there's no hiding.

[B2-10, page 21]

What is it about the treatment that you feel you need?
Well even the confrontation for changing. I need people to point out what's wrong with me cos I can't always see what's wrong with myself. I find it useful, constructive criticism to bring about change.

[B2-11, page 2]

The process of change seems to be further assisted by the *exposing of blind spots and feedback from fellow group members*:

... it exposes the blind spots doesn't it? What one person does not see another person does. So one counsellor, despite the best intentions, might have a blind spot themselves about something but if you've got a group of eight people they'll all see something different won't they? So there is a greater chance of getting the fuller picture...

[B2-10, page 23]

... people will pick up on things which I don't necessarily see in myself you know they're my blind spots so it works in that way and that's beneficial because it gives me an opportunity to change it then...

[B2-12, page 9]

The client-counsellor relationship was also talked about as being imperative to the participant continuing in treatment. The counsellors' non-judgmental attitude and empathy was referred to as being essential during the treatment process as is highlighted in the following quote:

> The one-to-one's I found comforting. My counsellor was very empathic - excellent, excellent. He doesn't just use his head, he uses the heart and they [the one-to-ones] gave me strength...
>
> [B2-1, page 14]

The general consensus among the participants was that it was beneficial having counsellors who were recovering alcoholics/addicts. They perceived that these counsellors were better equipped to understand the problem:

> ... The counsellors had been there, seen it, done it, and got the t-shirt so they know what they're talking about...
>
> [B2-3, page 12]

> ... being with people who understood where I was and what I was going through and you know the likes of [my counsellor] and [the treatment agency manager] who'd been in the same position as me in the past. I hadn't had that experience before of actually talking to recovering alcoholics – that made a big, big difference to me. Therefore, having their full support you know, people really rooting for you. I think that was important.
>
> [B2-5, page 11]

> I'd feel with respect to the counsellors... who aren't recovering addicts, it's one thing to know something in theory but it's another thing to ... actually go through the process or to know what it feels like... So I would have thought that it must be a key to the success of addictive therapy if the person enabling the process is a person in recovery themselves. That's not to put all non-addicted counsellors out of business but there has to be some depth of understanding there because it's an emotional thing rather than a physical thing. So it's not like a surgeon knowing what to do as a technique, although technique does play a part in counselling undoubtedly. But in terms of actually understanding it from the inside...how does somebody who does not have a craving understand a craving?
>
> [B2-10, pages 22 & 23]

While in Primary treatment there is an expectation that clients will attend three fellowship meetings such as *Alcoholics Anonymous* per week. These meetings provide an opportunity for recovering alcoholics to meet regularly and provide support for each other's recovery.

8 out of the 14 participants had attended AA prior to accessing the treatment agency. For the majority of the participants, AA was viewed as a "lifeline".

> They're [AA meetings] extremely important, it's like mental medicine... they've become very important to me, even though often I don't say anything... but just listening and just being there really does help. It's like a strengthening.
>
> [B2-1, pages 8 & 9]

Participants explained how AA meetings provide a forum for them to talk openly about their thoughts and feelings.

> ...I think one of the things that clinched the thing for me [that I was an alcoholic], was when I went to my first AA meeting and these people were talking about their feelings and I thought I'm in the right place because I know what these people are talking about... it is good to have a place to go to be able to get in touch with the thing that causes the alcoholism - which is the inability somehow of the alcoholic to deal with feelings... it seems logical to say that if alcoholism is a disease of the emotions of which the drinking is a symptom then ...like a diabetic needs sustained medication then you need somewhere to go to talk about feelings with people who will accept what you are trying to say.
>
> [B2-10, pages 16 & 17]

One participant from the aftercare sample remembers being advised to attend AA during his assessment at the treatment agency. He stopped drinking 4 days after attending his first AA meeting which he believes was prompted by hearing other people share their experience:

> ... I felt at home [in the AA meeting]. I was in poor shape, somebody made me a cup of coffee, I didn't have to say anything and I think I must have been very lucky because I heard everything I needed to hear...
>
> [B2-3, page 5]

The *sharing of expe*riences in AA is still just as important for this participant, who is now two years in to recovery:

> I've gotta talk to other drunks and if they're new in recovery, it reminds me where I'm from ...
>
> [B2-3, page12]

Initially, AA seemed to provide a place or refuge for participants when they felt they did not fit in anywhere else. They described a sense of *acceptance/belonging*. Even after completing treatment, some participants mentioned that they still experienced times when they felt they did not fit in anywhere except at an AA meeting.

Alcoholics Anonymous do not keep a register of attendance at meeting, this allows *flexibility* for people who may wish to increase (or decrease) the number of meetings they attend. Participants described various reasons they would increase the number of meetings attended per week. The most commonly cited reason was that meetings were increased during difficult times when the participants felt that they required more support.

> I only split up with my finance last weekend so I've stepped my meetings up from three to four even five a week now cos that's common sense, I need to talk about my emotions. Alcohol's not my problem, I haven't got a problem with alcohol. I don't suffer with alcoholism, I just live with it. It's what's between my two ears that's the problem, I mean two dangerous things for me is drinking and thinking. I haven't got a problem with drinking anymore so the dangerous thing for me is thinking.
>
> [B2-2, page 22]

However, increasing meetings was not only about needing more support as the quote below highlights. Some participants would make an effort to attend meetings they did not usually frequent to interact with people they may not have previously met. Sometimes the increase in meetings was due to the sheer convenience of a meeting and the participant being in the right place at the right time.

> ***Was there a reason behind why sometimes you'd go to four meetings?***
> ... it'd be a different meeting and you'd see different people who'd have different view points... and convenience as well, if I was near one...
>
> [B2-1, page 8]

The general consensus among the participants was that the treatment programme and AA conplimented each other providing an *integrated approach* that was well balance:

> The [treatment] Centre saved my life, got me sober; AA keeps me sober.
> [B2-14, page 2]

> AA keeps me sober. And I think WGCADA have explained who I am... and I need both of them.
> [B2-7, page 6]

The participants felt that AA *strengthened their recovery*:

> When I started here [the treatment agency] I was told, 'Treatment is treatment. AA is recovery.'... being a condition of treatment to attend AA meetings, it builds up that... that when you finish treatment you're still going to go to AA and then there's less chance of a relapse and ending up back in treatment.
> [B2-3, page 12]

Furthermore as the 12 Step programme is a programme for life, participants explained how AA provides an ongoing opportunity to continue *growing*:

> It doesn't all have to happen today, you know, this [programme] is for life. It's not a perfect programme; it allows for everything... I just want to keep making a bit of progress...
> [B2-3, page 10]

Participants were asked whether they found group therapy, one-to-one counselling or AA meetings most beneficial for their recovery. Out of the seven participants who had completed group: five said group therapy; one stated that "it was all recovery" to him; and the remaining participant felt that her one-to-one counselling was most beneficial, however due to work commitments she worked through Steps with her counsellor in a one-to-one setting. Of the remaining seven participants (who were still in treatment at the time of the interview): three felt that all three components were just as important; three said group therapy; and one felt that her one-to-one sessions were most important.

4.5. Spirituality

- **Reassessment of pre-conceived/current ideas of spirituality**
- **Open-mindedness**
- **Spiritual experience/Spiritual awakening**
- **Forming of relationship with the Higher Power**
- **Relinquishing control – Learning to let go**
- **Freeing relief**
- **Spiritual growth/development**

The 12 Step programme is notoriously known for its spiritual nature and this was self-evident from the participant interviews.. Step 2, *"Came to believe that a Power greater than ourselves could restore us to sanity"*, proved difficult for some participants causing them to *reassess their preconceived/current ideas of spirituality.*

One participant from the aftercare sample explained how initially her upbringing as a Roman Catholic hindered her ability to believe in "a Power greater than ourselves":

> ... I was brought up a Roman Catholic and anytime the word God is mentioned I got all these fears of fire and brimstone and having a black soul and you know the devil and everything... so I struggled with the word God/Higher Power...
>
> [B2-1, page 6]

Four out of the seven participants, who had completed the treatment programme at the time of the interview, had a religious upbringing. The remaining three had become indifferent about their faith so Step 2 for them involved a process of re-assessing their thinking around spirituality.

> ... during my drinking it had been really difficult for me because coming from a Christian perspective I couldn't understand why I couldn't sort out my drinking. If I had a faith, why couldn't I deal with this? And I then just sort of turned my back on my faith during the darkest time of my drinking cos I thought, 'Well, God's not here for me'...
>
> [B2-5, page 7]

Another participant, who had completed treatment, mused over the concept of faith and how even though he came from a Catholic background and believed in God, when he initially entered the treatment programme he no longer had faith in Him:

> ... I suppose you could say I was a man of great faith, whose faith didn't keep me sober. So I didn't have faith in that faith then - if you know what I mean? So I came to believe and had faith in that faith again. I'd believed God was there but I didn't have no faith in him so that faith was reinstalled in Step 2... it was mind blowing, it was really good.
>
> [B2-2, page 25]

Commonly participants talked about questioning the presence of a Higher Power because if there was such a Power why were they alcoholics and why had they suffered so much?

> ... all the way through my using I had no faith, no faith in anything – 'If there was somebody or something up there then this wouldn't have happened to me, that wouldn't have happened to me!' All this long list of things that wouldn't have happened to me if somebody had been looking after me when the reality is, if you look at it with a clearer mind, I'm lucky to be here really. So something did look after me. By rights I should be dead especially through that end part of drinking and using you know? It was Russian roulette, I was mixing so many things. I am very lucky to still be here...
>
> [B2-12, page 7]

> ... after a while I came to believe that there was a Higher Power because of all the car accidents I've been in, all the times I should've overdosed and I didn't, I didn't die or didn't get sent down [imprisoned]. There was someone looking after me...
>
> [B2-8, page3]

Some participants explained how they had to abandon their pre-conceived notions of spirituality (and the 12 Step programme) as *open-mindedness* was paramount to their recovery.

> I was never brought up with religion but I knew people that were in recovery and their definition of God wasn't the conventional sense so I knew it was working for them... it works through in lots of ways you

> know, it works through your sponsor, it works through other people in meetings and stuff like that you know. So they are all a power greater than me as far as I'm concerned. Left to think alone, then that's dangerous for me you know so…
>
> [B2-12, page 7]

Their open-mindedness led participants to describe *spiritual experiences or a spiritual awakening*. For example, one participant explained how on the day that he was no longer homeless a "spiritual experience" took place:

> … the place I stayed was run by Catholic nuns. They believe that everyone who stays there was obviously guided there. At the time, I was basically on the streets, you know, and in a bad way really suffering from alcoholism – not washing, not eating, not anything, just totally in a mess. You know, I ended up on their front door and as I said, I was taken in. So I believe [it was a spiritual experience]… it was an overwhelming feeling.
>
> [B2-4, page 7]

Another participant explained how his "spiritual experience" occurred when he was doing his Step 5 *"Admitted to God, to ourselves, and to another human being the exact nature of our wrongs"*. He spent approximately five hours doing his Step 5 with a Vicar:

> I told him [the Vicar] everything… the only other person I would tell them things would be God… when I finished the bad stuff and came on to the good stuff I had… what a person who is not a Christian will define as a spiritual experience or encounter. I had a massive rush of energy… go from the base of my spine right up to the top of my neck and then it like came down my arms to my fingers – it's gone, it's dealt with…
>
> [B2-2, pages 21]

Five out of the seven aftercare participants described these spiritual experiences as subtle rather than overwhelming experience as described above. For these individuals, significant others, i.e., family members and/or friends, noticed a change in the person.

> … close friends and relatives… they were saying, 'We can't believe the difference!' or 'We can't believe it! What's happened to you?' And I had people saying to me, you know, 'How have you done it?' 'What is it?' you know?... And it was amazing, just people's reaction…

What would you're reply be to the people who were asking you, 'How have you done it? What's happened to you?'
I would say two things; I would talk about a programme that I'd been through and I'd talk about the fact that it was really a programme for life not just alcohol recovery. And I did actually give away some of my booklets (laughs) to friends, you know, 'You haven't got a drink problem, but read this!' It was all about coping with life and we'd have a lot of discussions... and it was really exciting just being able to sort of share some of the stuff that I had learnt and sort of take it out of the alcohol context. And secondly, I think the difference as well, you know I'd be able to talk to people about my faith as well and just say that, that really played a fundamental part of what changed with me and in me, and it helped me.

[B2-5, page 12]

One participant explained how the spiritual aspect of the programme caused a chain reaction for him:

... I had to believe in God, by believing in God I believed in AA and by believing in AA, I believed in the Steps, by believing in the Steps I started believing in myself...

[B2-2, pages 14 &15]

Participants' *relationship with their Higher Power* changed as they progressed through the treatment programme.

Step 2 has sort of given me hope in a way you know, believing that there is something that's bigger than me to restore me to sanity cos I can be insane in recovery, it's not just about the drink and drugs anymore. Its about me as a person so having a belief in something, I don't know what it is you know, I'm not religious, I don't find my Higher Power in the church, not to say... I don't know... I mean that would probably develop over time you know? I'm not closed to the idea of God but it doesn't really work for me at the moment but my perception has changed over time from when I first came in to recovery to now. So for me it just gives me hope you know...

[B2-12, page 5]

One participant from the aftercare sample, who defines his Higher Power as God, described how initially his Higher Power was a film star:

> I was accepting it [the disease concept] with my mouth for months and months but I was still relapsing, but I was using Bruce Lee as a God, completely sober but it's not going to work is it? He's just a martial artist - a film star...
>
> [B2-2, page 14]

Five out of the seven aftercare participants named God as their Higher Power. These participants felt that it was very important to have an abstract Higher Power if abstinence and sobriety were to be sustained.

> ... I think on a basic level it's whatever that person can gain strength from. On another level, I suppose to me I find my faith to be so, so helpful and important, and such an integral part of my life now that, how can I say it? I suppose if someone sees the group as their Higher Power, I'm thinking, 'How can they get strength from that, that I get from my faith?' I can't imagine that I would get direction and help and guidance just seeing the group as my Higher Power. But I accept that AA teaching you the Higher Power is something we leave to people's own interpretation, and therefore if I go to AA meetings I will talk about my Higher Power but I will not preach about what that is cos that's not what we do at AA... in AA, you're not out there proselytising are you? I can't go in and talk about my faith in a specific way... I do find it difficult sometimes because things happen and they're such a help to me but I can't share the detail because AA is very much about you talk about the Higher Power but you don't talk about what the Higher Power is specifically.
>
> [B2-5, page 8]

Interestingly of the remaining seven participants, who were still engaged with the treatment programme at the time of the interviews, only two named God as their Higher Power. One of these participants was on Step 2 and the other was on Step 3. However the remaining participants talked about their Higher Power in a spiritual way:

> ***What is your Higher Power?***
> My Higher Power is not a person, its not God, it's not Buddha or anything like that. I'm not religious... my Higher Power for me is if I get a piece of chalk and draw a circle around myself then anything outside of myself that I cannot control in any kind of way is a power greater than me...
>
> [B2-8, pages 5 & 6]

How would you describe your Higher Power?
I don't have a particular description... I don't want to put one thing on it cos I think it's many things. I think putting a label or a description on it would ruin it for me. It's too much, it's big, it's a Higher Power. It's bigger than everything to me. I don't know why I am here so that's the Higher Power working for me in the simplest terms. I survived all these years against great odds what's that? It's not medical science that kept me alive. Medical science created the drugs that I put into my body... It's something larger. It's the whole picture that I see. It's the whole thing. It could be a member of the group would say something to me that would save me that day. It could be someone giving me a hug after an AA meeting that made me feel better. It could be someone ringing me. It could be someone smiling at me on the bus even... sometimes a smile back from someone can make your day...

[B2-6, page 17]

Participants described how *Step 3 "Made a decision to turn our will and our lives over to the care of God as we understood Him."*, was about overcoming self-will, *relinquishing the need to control* and accepting their Higher Power's will:

... I was finding out what God's will was and handing it over to God as I understood him... I knew when I was running on self-will because I would become restless, irritable and discontent. I knew I was doing my thing my way. Always going overboard, obsessions would come back in... Step 3 for me – is seeking God's will. If you seek it you will find it... Step 3 is a practical Step I find.

[B2-2, pages 18 & 19]

Once participants began accepting their Higher Power's will, they described a sense of a *freeing relief*:

... there's a friend, a powerful friend there not so much to take flack but to assist, it doesn't all have to be on my shoulders... It's a relief. It's a freeing relief not to worry that if it goes wrong then it's my fault.

[B2-1, page 7]

It's just given me so much hope and so much faith that whatever happens in life good or bad, things are going to be okay...

[B2-8, page 5]

Step 3 was cited by the participants as paramount for their *spiritual development*. In the following quote a participant from the aftercare sample explained how Step 3 enhanced her spirituality:

> I think [Step 3] helped me to realise that actually it was my faith working out that had got me to where I was then, at Step 3, and I could build on that. It was a very important time for me... I was beginning to see my Higher Power, which would be God, sort of working through the programme and working in me, you know? That was really a great foundation Step 3.
>
> [B2-5, page 7 & 8]

> Step 3 helped me to put it in to context again and to actually understand that the God as I understand him didn't hate me because I was an alcoholic, and hadn't deserted me even when I was drinking too much. ... Yes I am a recovering alcoholic but I can have a faith in God and I can have a very positive relationship with God... so Step 3 was really important for me to sort of accept myself and know that I was accepted.
>
> [B2-5, page 11 & 12]

4.6. Recovery

- **Acceptance of the disease concept**
- **Maintaining abstinence**
- **Awareness of powerlessness over the disease**
- **Open mindedness & faith**
- **Honesty**
- **Daily inventory/self-awareness**
- **Self-responsibility**
- **Positive reinforcements of new identity**
- **AA involvement/Giving back**
- **Constructive use of time**
- **Active process**
- **Humility and Serenity**

The 12 Step model views recovery from alcoholism as life-long process. The participants explained how the treatment programme provides them with the tools that enable them to achieve and hopefully maintain sobriety. However, the participants felt that ultimately they had to put these tools in to action. A key concept for sustaining abstinence for this sample group was the *acceptance of the disease philosophy.* For example, a participant from the aftercare sample recalled relapsing after receiving an inpatient detox. Her relapse helped her to accept the disease philosophy as she feels she has "proved" it to herself:

> ... a week after coming out of [an inpatient detox] the first time... It was as if I was standing besides myself in the shop and I said, "Oh half a bottle of vodka please." as I usually did... In a way I'm glad that happened to me cos if it hadn't have happened to me it would still be in my mind, 'I wonder... I wonder... I wonder...' so it did happen, it's been proved to me. I proved it to myself... that I can't drink.
>
> [B2-1, page 10]

By accepting that they have a disease, participants recognise that they have to *maintain abstinence* from the substance that perpetuates the disease:

> ...purely for an alcoholic an abstinence programme is the only one that is going to work.
>
> [B2 – 10, page 22]

Participant talked about how they had exchanged wilfulness for willingness, admitting their powerlessness over the disease *(refer to "The Treatment Process" section for a more detailed discussion).*

Participants cited *open mindedness* (re: spiritual concepts) as extremely important for their recovery. Furthermore, *faith* in the programme and *faith* in a Higher Power *(also see section on "Spirituality")* are paramount. How can one sustain sobriety when that sobriety is based on a programme that they have no faith in?

> ...I know a guy who was sober for 20 years; he relapsed but he wasn't very much in to the spiritual handle... if I stop believing in a Higher

> Power and in the programme I'm just gonna backslide then – go out get drunk and things are going to be worse... I've got to keep making progress.
>
> [B2-3, pages 11 &12]

> ... it [the Big Book] says you will experience pain, you will feel the pain more because now you cannot anesthetise yourself [by using alcohol] but you will have a programme and you will have some idea of God as you understand Him to deal with it and if you follow that it's impossible for you to drink. If you drink then there's a chink in your armour and you haven't done a solid Step1...
>
> [B2-2, page 22]

Participants explained how the treatment programme calls for *honesty* and integrity. For clients to be able to make behavioural changes (and build on these changes) they need to take an honest look at themselves. *Self-awareness* is the key to making changes. Clients are shown how to take a *daily inventory*. One participant from the aftercare sample, explained how at the end of each day they write down what tools for recovery they used that day asking themselves questions such as, "How did I work the program today?" or "Did I say or do anything that I need to make amends for?" This allows them to identify areas that may need more work. It also helps them identify the things that they are doing well. The daily inventory helps chart their growth in recovery.

> ... It makes me look at almost every aspect of what I do and how I react to people. I'm not looking at myself constantly... but taking your inventory at the end of every day – being taught how to take an inventory at the end of the day is an excellent touch stone for life.
>
> [B2-1, page 11]

The participants have *self-responsibility* for becoming aware of and modifying their behaviour. As one participant from the aftercare sample alluded to - with the tools he learnt in group therapy, he is now able to work through these issues on his own:

> I remember things today, you know little memories come up and now I can break them down without the group around me. I can disassemble them and reassemble them... I've been given the resources to stay sober and it's up to me to use the tools and get on with it then.
>
> [B2-3, pages 9 &10]

A participant on Step 3 used the analogy of writing a diary to explain how the Steps work:

> ... the only way I can describe working the Steps is having a diary and turning the page and this time I'm in charge of the pen... before the drink controlled me.
>
> [B2-14, page 5]

Working through the Steps allows the participants to realise that their behaviour does have consequences:

> It's made me look at myself. It's made me realise what I do and what I say does have consequences because I'd been drinking so long, I forgot that what I'm doing does have consequences...
>
> [B2-1, page 11]

Frequently participants talked about not knowing who they were when they stopped drinking.

> I lost so much through my alcoholism and I think mostly, I lost myself. I didn't know who I was.
>
> [B2-4, page 8]

Participants explained how their emotional development was arrested as a result of alcohol, i.e., they stay at the age they were when they had their first drink, and therefore treatment and recovery are part of the growing process:

> You grow in treatment and grow in recovery. They [the counsellors] reckon that when I first picked up a drink that I stayed at that age, you know, cos mentally I stopped growing.
>
> [B2- 4, page 8]

> ... once I started drinking... it certainly seems to have closed my mind and arrested my development as a person.
>
> [B2-3, page 1]

> The biggest thing the treatment has done for me is it taught me to grow up...
>
> [B2-2, page 26]

> ... It [the treatment programme] helps you become another member of society... people can walk past me and not fear me. It's helped me be responsible. It's helped me grow up, I was a Peter Pan who never wanted to grow up...
>
> [B2-8, page 11]

> That's the thing I've learnt... that it's okay to feel the feelings cos I think that's the strangest thing having not felt any emotions in any normal fashion... you're bombarded with the lot of them. All whomph! And sometimes they are so intense...they call it an emotional roller coaster. And it's the biggest twister I have ever been on. It's absolutely crazy.
>
> [B2-6, page 8]

Inevitably participants describe how they undergo a process of building a new identity.

> ... I feel like the old me has been taken out and put to the side and that's weird being that kind of new person.
>
> [B2-8, page 10]

In order for this *new identity* to be sustained *positive reinforcement* are required in the form of experiences which demonstrate the benefits/advantages of being alcohol-free.

> I'm much more self-aware and I know my limitations but it's [the treatment programme] also made me recognise how positive a life without alcohol can be, and I know my life now is better than it was before I had a drinking problem - not necessarily the circumstances of my life, but what makes me tick.
>
> [B2-5, page 11]

> I've started to believe I'm a good person finally... I used to believe I was a piece of shit – I was worthless and I don't believe that at the moment ... so that's how it's changed me and it's given me all the tools to deal with life on life's terms. Friendship, love and life it's as simple as that. I'm sorry I am getting emotional now. What hasn't it given me! They say it's a life beyond your wildest dreams - well that's a bit of an understatement... I see things now - it's like they've given me a new pair of glasses [laughs]. The beer goggles have gone now!... I can cry when I

> want to cry and I can laugh when I want to laugh... I'm learning what I like... I didn't know what I liked... I know that I like putting The Clash's first album on full throttle while I'm having a bath. I know that I like scrambled eggs in the morning. Dandelion and Burdock is the best drink ever! [laughs] ... The smallest things that people take for granted are the most important things in life... I know I'm going to feel the shit things as much as them [the good things] but the good things outweigh the bad things 10:1 easily.
>
> [B2-6, page 22]

> All I know is what I've got now, I didn't have nine months, two weeks ago... I can be content with myself. And I can also be unhappy with myself. But it doesn't matter - I can live with that... today. [Someone in the fellowship] used to say to me that perhaps I was lucky, 'You got off the bus before the bus has got to the terminus' or something like that, 'You've got off, now don't get back on cos there's a lot further [you could go]' and I suppose there is a lot further I could have gone... and I was going that way. I do consider myself lucky... I haven't lost what a lot of other people have lost, but I had lost enough. I'd lost myself and it has taken me a long time to work that one out – with a lot of help.
>
> [B2-7, pages 13 & 14]

The general consensus was that changes in self usually occurred gradually and other people such as family and friends noticed the changes before the individual:

> ... they [close friends and relatives] were saying, 'We can't believe the difference!' or 'We can't believe what's happened to you!' And I had people saying to me, you know, 'How have you done it?' 'What is it?' you know?... And it was amazing, just people's reaction because I think I was different, as well as not drinking, I was different. I was more positive, and I was more in control of myself.
>
> [B2-5, page 12]

> I find it nice when I see somebody I haven't seen for a long time and you know, you can get the obvious, 'Your looking well!' or, 'Your looking really good!' but when they can say, 'Are you on something?' and I say, 'No actually I'm not!' or 'I am but it's called not on anything!' [laughs]
>
> [B2-7, page 16]

The new identity is further substantiated by improved relationships:

> I've always found it difficult interacting with people on any level you know? But the further I've come in to this treatment the better it's getting for me. It's not as fearful now going in to certain situations and having to have conversations with people. I was terrible before, I could never communicate with people properly. It's improved so many things in my life you know my relationship with my mum and dad. We actually communicate now whereas before it would be shouting because that's all I'd know... being able to be there for my family when for years I put them through hell. It has improved my relationships and given me the ability to form relationships which before were very superficial cos I couldn't let anybody get close to me. I was so frightened of anybody finding out who I was you know? I was this horrible person that had done so many bad things... but I'm not doing them now, I'm not really that person...
>
> [B2-12, page 12]

Participants talked about how their *AA involvement* was important in sustaining their recovery *(refer to previous section, "The Role of Alcoholics Anonymous")*. Participants' explained that the final Step involves carrying the message of hope and recovery to other alcoholics *(Step 12 "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs")*. This was important to participants as they felt they were "giving back"/repaying the help that they had received.

> I'm on the Helpline for AA and a lot of people are all mixed up. They're asking for help. They don't want to give their names. They don't want to give their telephone numbers. They don't want anyone to call, and you've got to talk and convey to these people, 'I've been there where you are now and you can come where I am.'... you've got to give them hope.
>
> [B2-3, page 8]

Constructive use of time was also cited by participants as being important for their recovery. For such a long time alcohol had been the driving force of their lives, they had to learn to fill the void left now that they are abstinent.

> ... I look at it as having a long love affair. When I first met alcohol, we had a really good time together. We were so happy together. We thoroughly enjoyed each other. We lifted each other up... and then the rot started setting in and the arguments started like in a long term

> relationship. I ended up hating alcohol, and alcohol ended up hating me, so we split. I ended the affair but it's left a huge hole inside me, I need something to fill that. It's like the end of a long love affair when you meet someone you love and love dies and leaves a huge hole in you that needs to be filled.
>
> [B2 - 1, page 16]

All of the participants recognised that their recovery was an *active rather than passive process*:

> I've been given the resources to stay sober and it's up to me to use the tools and get on with it then.
>
> [B2-3, page 7]

Participants explained that change can happen if the person is prepared to work the Steps, as put quite simply by a participant from the aftercare sample:

> ***Why do you think they [the Steps] work?***
> They work if you work them, that's the only way I can put it.
>
> [B2-4, page 7]

Humility and serenity were viewed as vital for recovery. Participants, especially those in the aftercare sample, explained how humility and serenity helped them to surrender and stop trying to fight the reality of their situation (i.e., that they are alcoholics). This ultimately led to feels of contentment:

> It's [treatment programme] taught me lots of tools, not only how to stay off the alcohol but how to live a better life cos I didn't come off alcohol to be a misery guts!
>
> [B2-1, page 11]

> I think it's [the treatment programme] has just enabled me to be free – I've got a choice today which I didn't have before. It's given me the choice, I can have a future. I don't know what sort of future I'll have but I've got a choice I can either have the past or a future... I don't want what I had before...
>
> [B2-7, page 12]

I'm not 100 miles an hour now, I'm more like 70 miles an hour – the legal speed limit. I slowed down and I was more at peace with myself... it's [the treatment programme] an effective tool and it's a bridge to normal living. It's powerful stuff... people say it's brainwashing – well brainwash me then!... It's washing out all that crap, 'cos that crap nearly killed me.

[B2-2, pages 25 & 26]

SECTION 5: DISCUSSION

5.1. Qualitative Methodology

Prins (1995) suggested that more qualitative research looking at why and how people get into and out of addiction, is required to enhance our knowledge about the contribution of treatment interventions in facilitating recovery; what works, for whom and under what circumstances.

In the present study, semi-structured interviews were conducted in order to gain a detailed picture of the process of recovery from alcohol addiction via a 12 Step community-based treatment programme. According to Smith (2001), semi-structured provides much more flexibility than the more conventional structured interview, questionnaire or survey, as the respondent gives a fuller picture and the researcher is free to follow up interesting avenues that emerge in the interview.

When carrying out a qualitative study of this nature, there are several important issues which need to be considered. When conducting interviews, particularly on topics as sensitive as addiction and recovery, it is essential that trust is established early in the interview and that a good rapport with the participants is established. To assist this, participants were reminded of their anonymity in the research, and the interviews were conducted as informally as possible, on a one-to-one basis to ensure that a conversational style of interview developed. The informal atmosphere of the semi-structured interview has been reported to allow respondents to explore honestly amd freely their findings, motivations and behaviour (Langley, 1994; Miles & Huberman, 1994). Since this study covers a sensitive subject certain ethical considerations needed to be addressed, since it was possible that the interview might raise particularly upsetting emotions for the participants. In order to avoid potential problems, participants were reminded that they did not have to answer any questions that they were uncomfortable with and that they were free to pause or terminate the interview at any time.

Grounded Theory was used to analyse the interviews. According to Strauss and Corbin (1990), this method of analysis is different from other methods in the sense that it allows the generation of theory that closely approximates the reality it represents, rather than the testing of theory. Although the process of transcribing the semi-structured interviews for analysis was labour intensive, it was deemed necessary in order to achieve sources of data that were detailed and rich enough to analyse successfully.

5.2. General Discussion of Findings and Implications for Treatment Delivery

A detailed account of the interview data has been presented in terms of six major phases of recovery (i.e., categories), which emerged from Grounded Theory analysis. Within the categories, numerous concepts and sub-categories have been highlighted. These categories have been presented separately to avoid ambiguity; however they do overlap.

The first major category that emerged was the descent into addiction. Although this was one of the smallest categories, it is highly significant as in order to understand the process of recovery, one needs an understanding of addiction and exactly what the addict is recovering from. Participants' explained how they experienced positive reinforcement of their early alcohol use. They recalled happy memories of times when they drank alcohol. Interestingly the majority of the participants' recalled that they were aware that they drank differently to their peers from a young age. For example, some participants talked about how they found it strange that their friends were able to stop at one or two drinks whereas they always wanted more - one drink was never enough.

Participants described a gradual increase in their alcohol consumption; they began to drink more frequently and in larger quantities. This unconscious 'drift' rather than a deliberate decision to drink regularly supports the findings of McIntosh and McKeganey (2002) who discovered similar results with a cohort of seventy ex-addicts. Even though the participants' alcohol consumption was increasing, they still perceived that they were in control of their alcohol use. This concept of perceived control was enhanced for some participants as they were able to abstain from alcohol for periods of time. Furthermore, they did not accept that they had an alcohol problem as they were not behaving in the

way that they perceived an alcoholic would, e.g., not drinking first thing in the morning, and/or being able to maintain a job. However, for all participants there came a time when they concealed the amount that they were drinking from their loved ones and friends. Twerski (1997) explains that an alcoholics deluded idea of control is linked to their misunderstanding that addiction is a moral failure rather than accepting that they have a disease. Twerski refers to this as a "delusion of omnipotence" and the addict must realise that they are not in control of some aspects of life.

The second major category to emerge from the present study was the gradual process of realisation of the problem. Contrary to the perceived control participants described in the previous category, participants went on to depict a loss of control over their alcohol use. As their alcohol use continued to increase so did their tolerance levels. Participants explained how they became preoccupied with thoughts about alcohol; experiencing compulsions and cravings. As the problem progressively took over their lives, participants seemed to lack any sense of choice over their addiction.

Inevitably as the participants alcohol use became all consuming, negative consequences followed. These negative consequences varied from losing a job or home, neglect of self, physical and/or psychological deterioration, break down of relationships and/or involvement with the criminal justice service. Similarly to the findings of McIntosh and McKeganey (2002), it was clear that many participants lacked a sense of responsibility whilst in active addiction. In particular, the effect that the participants' alcohol use had on their relationships with family members evoked the most emotion when the participants were recalling numerous memories of arguments and a tense atmosphere within the family home.

Interestingly even though participants were experiencing negative consequences as a result of their alcohol use, they described a delay in accepting that they had a problem. McIntosh and McKeganey (2002) found that the time delay in individuals recognising that they were addicted varied from a few weeks to several months or even years dependent on what drug they they were using and whether they were able to support

their habit. In the curent study, the delay in accepting the problem appears to have been enhanced by the positive and negative reinforcement participants experienced when they consumed alcohol. Participants explained that even though they were experiencing negative consequences through their alcohol use, "good times" were still being had which made them reluctant to accept that they had a problem. Also, participants described that negative reinforcement played a role as alcohol allowed them to block out the emotions that they did not want to feel. Participants explained how they would make excuses to themselves and others to justify their continued alcohol use.

Denial also played a part in the delay participants described in accepting that they had an alcohol problem. This denial was reinforced again by still having "good times". There were times when participants felt psychologically and/or physically that they could go no lower; however they bounced back and soon that lowest point became a distant memory. One participant referred to these exeriences as "trampoline rock-bottoms". This further enhanced participants' denial that alcohol was a problem. Numerous researchers have found that deciding to give up drugs was surrounded by a great deal of ambivalence, with a conflict between a desire to change and a reluctance to give up the drug (Biernacki, 1986; Prins, 1994; and McIntosh & McKeganey, 2002). This view is also reinforced by the stage theorist Frykholm (1985), who argued that the first phase of de-addiction involves a period of ambivalence, where the negative effects of drug use are increasingly felt which results in a gradual desire to stop using drugs which is generally offset by a continuation of pleasurable effects of the drug and a physical dependency. The presence of such ambivalence clearly implies that there is a potential role for therapies such as Motivational Interviewing (Miller, 1983; Miller & Rollnick, 1991), which explores ambivalence, and aim to facilitate compliance and readiness for behaviour change.

Participants gradually came to accept that they had an alcohol problem. This gradual acceptance of the problem was enhanced by the emotional and/or physical pain (withdrawal) participants experienced. Similarly other research has shown that

deteriorating health or fear of health problems is a significant factor in the decision to abstain (Waldorf, 1983; Vallient, 1983; Simpson et al., 1986).

Addiction is commonly assumed to be characterised by chronical relapses (Gossop, 2002). All of the participants in this study recalled unsuccessful attempts at controlling or stopping their alcohol consumption. Hence one of the goals of Relapse prevention models, such as that of Marlatt and Gordon's (1985), is to teach clients to anticipate the possibility of relapse and to recognise and cope with high risk-situations. Once high risk situations have been identified, various strategies can be used to lessen the risks (Larmier et al, 1999). However, as McIntosh and McKeganey (2002) believe failed attempts at giving up a substance are not simply a waste of time, in fact they play a highly significant role in the recovery process, as a period free from drug use can often clarify and highlight the extent to which addicts' identities have been damaged by drugs. Furthermore during abstinence, the addict can acquire a first-hand experience of the alternative life to which s/he might aspire.

As in McIntosh and McKeganey's (2002) study, all of the participants used the drug on a daily basis; there came a time when they felt that they needed alcohol to function normally and avoid withdrawal. This daily routine led participants to feel exhausted. They described feeling a sense of hopelessness and desperation. Participants felt unable to cope without alcohol and furthermore, due to their previous unsuccessful attempts at trying to reduce/control their alcohol use, they knew they could not give it up alone. Hence there is the obvious but difficult need to make treatment more accessible/available to addicts, and the need to promote treatment services, which support self-efficacy.

Participants frequently referred to how alcohol made them feel like a different person and affected their lifestyle and identity. The negative consequences they experienced as a result of their alcohol use often led to them having feelings of guilt and shame which inevitably led them to drink to alleviate these feelings. They described how they disliked the person they had become. Similarly, in McIntosh and McKeganey's (2002) study, the

majority of participants referred to the negative impact that their lives as addicts had on their sense of self. McIntosh and McKeganey (2002) describe how a desire to restore ones identity is a necessary cognitive shift to prompt recovery; however this alone is not sufficient. They argued that addicts need to believe that change is feasible, without this any inclination to alter behaviour would simply disappear. Since addicts must believe that they have the power to change their behaviour, the enhancement of self-efficacy seems to be of considerable importance, and the role of skilled therapists can be particularly important in this respect (Edwards, 2000). The importance of taking positive actions to promote behaviour change is supported by Prins (1995). He argued that, although the decision to change/stop using drugs may be a decisive moment/turning point, very often it is not enough on its own and therefore the decision needs to be backed up by a plan of how this will be achieved.

The third category that emerged from the data was accessing treatment. All of the participants described a turning point or significant event that prompted them to access treatment for their alcohol use. This supports the findings of McIntosh and McKeganey (2002) who pointed out that there is considerable agreement regarding the importance of an identifiable "turning point" in the individual's drug using career; a point at which the decision to give up drugs is taken and/or consolidated (Prins, 1994; Simpson et al., 1986; Shaffer & Jones, 1989). Participants stated that this "turning point" is necessary for the recovery process to commence.

Ultimately their decision to access treatment was driven by them feeling unable to continue with their lifestyle. This parallels the work of Biernacki (1986) which cites 'burning out' as a recurrent reason why addicts bring their drug using days to an end; they become weary of their hectic lifestyle induced from sustaining their habit until they can not tolerate it any more. Similarly Twerski (1997) explained that recovery is prompted by a person experiencing a "rock bottom" or a significant turning point where abstinence is seen as a lesser distress than using alcohol. Furthermore, numerous researchers have found that the realisation that the drug is no longer a positive part of an

addict's life represents an important turning point (Stimson & Oppenheimer, 1982; Frykholm, 1985; Prins, 1994, McIntosh & McKeganey, 2002).

Many people believe that the experience of a "rock bottom" is essential for successful recovery; however this view has been challenged by researchers such as Biernacki (1986) and McIntosh and McKeganey (2002), who have identified two principal routes out of drug use. One route is the rock bottom type experience whilst the other exit is via rational decisions. The main difference between the two types of routes is having to stop in the former and wanting to stop in the latter. Although the present study seems to support the occurrence of the rock bottom type of experience, this does not mean that exit via the rational decisions are not important. The difference in the findings may be to do with the sample, i.e., they were accessing a specific type of treatment programme.

The concept of readiness was paramount to the participants accessing help for their alcohol problem. Edwards (2000) explains that addicts need to be motivated (and specific treatments like Motivational Interviewing are useful here), as well as being ready to change (a view strongly influenced by Prochaska et al. (1992) model). Participants felt that their previous unsuccessful attempts at abstaining from alcohol and/or reducing their alcohol consumption were because they were not ready and also because they were doing it for the wrong reasons, e.g., trying to hold on to a partner when the relationship was breaking down or to please their family. This supports the findings from McIntosh and McKeganey's study (2002) which identified that addicts' are most likely to succeed in their recovery from drug addiction, when their decision to stop using was instigated independently.

Eventually, participants contacted the treatment agency. For some participants, this decision to contact the treatment agency was influenced by the positive changes they saw in other people who were in recovery, people they knew that had accessed the treatment agency and/or people they saw in Alcoholics Anonymous. Twelve of the fourteen participants felt that treatment was a necessity for them. This finding supports Frykholm's (1985) treatment phase, in which it is proposed that the addict perceives a

need for 'external control and support' and so seeks help. The general consensus among these participants was that they needed to do the in-depth work on self. Hence, it was clear from the study that abstinence alone was not enough for the majority of the participants. It was viewed as prerequisite to recovery but for recovery to be sustained, there has to be a change in the person's thinking/attitude and behaviour. This finding supports the process highlighted by Twerski (1997).

The fourth category that came out of the analysis was the treatment process. From the analysis of the data, it emerged that the positive effects of treatment seemed to occur as a result of various components of the treatment programme. However, due to the lack of a no-treatment control group and random assignment this inference cannot be confirmed with confidence. The efficacy of substance misuse treatment itself is an interplay of individual variables, treatment variables and other environmental factors unrealted to treatment (Winters et al., 2000).

Specific to this particular treatment programme is the disease concept which states that alcoholism is a chronic, progressive and potentially fatal disease. Furthermore this disease can be arrested (by abstaining completely from alcohol) but not cured, i.e., an alcoholic will not be able to drink moderately like a non-alcoholic, for any sustained period. Essentially the disease concept views alcoholism as a health problem (a physical and emotional disease) rather than a question of willpower.

For some participants the initial non-acceptance of the disease philosophy appeared to be because if they accepted it then they were accepting that the only cure would be to abstain. Other participants explained how they superficially accepted the disease concept as it gave them a license to drink. One out of the five participants in the aftercare sample explained how initially she had found the disease concept hard to accept as she viewed it as a "cop out", and she felt uncomfortable about not taking responsibility for her actions especially where her family were concerned. However, she continued by explaining that the more she looked at her past behaviour, the more she

could understand why she had behaved in that way when put in the context of the disease concept.

This process of realisation was shared with other participants as they reflected on their past behaviour. Participants also explained how recounting previous relapses after periods of abstinence helped them to accept the disease concept, as they appeared to have no control over their alcohol use. Furthermore, hearing about other people's relapses assisted with participants' acceptance of the disease concept. Participants described experiencing a sense of relief when they accepted the disease concept as they finally had some answers to why they behaved the way they did. Acceptance of the disease concept allowed participants to deal with the guilt they felt around their drinking and the way they had behaved. Participants explained how their acceptance of the disease concept was eased by practising the "One day at a time" AA principle.

Participants talked about how the foundation for their recovery was laid during Step 1, i.e., *"We admitted we were powerless over alcohol – that our lives had become unmanageable"*. Seven of the participants had completed treatment at the time of the interviews. When asked what, if any, Step had been the most important for their recovery, the general consensus was that Step 1 was the most significant and also the most emotionally painful Step. Pertinent to this Step is participants' acceptance that they cannot control their use of alcohol (and other mood altering chemicals) hence the driving force of their life, i.e., the addiction, is beyond their control and they are therefore powerless over it. All of the participants described a gradual process of acceptance of being powerless over alcohol. Some participants explained that it was only after failed attempts at "controlled drinking" where they had unsuccessfully tried and tested their power over alcohol that they gave in.

Step 1 also deals with the person's unmanageability and the damage that their addiction has caused. The participants explained how they began to see the unmanageability of their lives by reviewing their drinking history. Furthermore, participants talked about how externalising their thoughts/feelings by doing the preparation work for, and

completing their life-story on Step 1 allowed them to deal with the feelings around the damage their drinking caused not only to themselves but also to their significant others. Externalising their thoughts/feelings was seen as part of the healing process. The general consensus among the participants was that the Step 1 work they did provided them with hope for a new life as they realised that change was possible. This supports McIntosh and McKeganeys' findings (2002) that addicts need to believe that change is feasible, without this any inclination to alter behaviour would simply disappear.

The treatment programme consists of group therapy and one-to-one counselling. When participants were asked about how they felt sharing personal information in a group setting, they stated that the process was helped by the controlled environment and level of assured confidentiality. The sharing of experiences and identification among the group appears to be enhanced by the trust among the group members which allowed them to speak openly and honestly about their drinking and the consequences of their past behaviour. Participants talked about how the sharing of experiences in the group setting makes honesty contagious. Glatt (1969) stated that group therapy appears to be a very suitable means for treating alcoholics as, although there are many different personality types among them, they share a common over-riding problem and their drinking history displays many similarities and common experiences which leads to a group member identifying with his/her peers.

Due to the level of honesty of the "shares" and identification, participants described feelings of acceptance and belonging – feelings that they had longed for, for some time. During their drinking days, participants had experienced isolation and loneliness. The sense of isolation is obviously something that needs addressing, and as this study shows, engaging in treatment can act as one means of rebuilding social networks with people who do not have an alcohol or drug problem.

Participants acknowledged the need for confrontation, also referred to in AA as "Tough Love", as an important tool in the treatment process to help them change their thinking and behaviour. The process of change seems to be further assisted by the exploring of

blind spots and feedback from fellow group members and counsellors. The client-counsellor relationship was also talked about as being imperative to the participant continuing in treatment. The counsellors' non-judgmental attitude and empathy was referred to as being essential during the treatment process. The general consensus among the participants was that it was beneficial having counsellors who were recovering alcoholics/addicts. They perceived that these counsellors were better equipped to understand the problem.

While in Primary treatment, there is an expectation that clients will attend three fellowship meetings such as Alcoholics Anonymous per week. These meetings provide an opportunity for recovering alcoholics to meet regularly and provide support for each other's recovery. Many of the participants described the benefits of being surrounded by people at different stages of their addiction. New/relapsing alcoholics serving as a reminder of consequences of drinking and successful recovering alcoholics providing hope and serving as potential role models or goals to aspire to. The various benefits of common experience are supported by McIntosh and McKeganey (2002), who describe three main advantages of talking to other recovering addicts. Firstly, recovering addicts understood first hand what the individuals were going through and were able to relate and better emphasise. Secondly, they had credibility since they had been there themselves and were knowledgeable. Thirdly, successful recovering addicts gave inspiration to those not so far along, sustaining the hope that they could succeed.

Eight out of the fourteen participants had attended AA prior to accessing the treatment agency. For the majority of the participants, AA was viewed as a "lifeline". Participants explained how AA meetings provide a forum for them to talk openly about their thoughts and feelings. The sharing of experiences provided the participants with an opportunity to identify with other people and served to remind them that they are not alone.

Initially AA seemed to provide a place or refuge for participants when they felt they did not fit in anywhere else. They described a sense of acceptance/belonging. Alcoholics

Anonymous do not keep a register of attendance at meetings. This allows flexibility for people who may wish to increase (or decrease) the number of meetings they attend. Participants described various reasons why they would increase the number of meetings attended per week. The most commonly cited reason was that meetings were increased during difficult times when the participants felt that they required more support. However, increasing meetings was not only about needing more support. Some participants would make an effort to attend meetings that they did not usually frequent as this allowed interaction with people they may not have previously met. Sometimes, the increase in meetings was due to the sheer convenience of a meeting and the participant being in the right place at the right time.

The general consensus among the participants was that the treatment programme and AA complimented each other providing an integrated approach that was well-balanced. The participants felt that AA strengthened their recovery. Furthermore, as the 12 Step programme is a programme for life, participants explained how AA provides an ongoing opportunity to continue growing. Glatt (1969) highlights the benefit of attending AA post-treatment in the quote below:

> The continued support after discharge from attending local AA groups is certainly of the greatest value in the rehabilitation phase... To sober up the drunk is not usually a very difficult task... It is much more difficult for the alcoholic to maintain sobriety once the active treatment has finished.
>
> [Glatt, 1969, page 120]

Participants were asked whether they found group therapy, one-to-one counselling or AA meetings most beneficial for their recovery. Out of the seven participants who had completed group: five said group therapy; one stated that "it was all recovery" to him and the remaining participant felt that her one-to-one counselling was most beneficial. However, it should be noted that, due to work commitments, she worked through Steps with her counsellor in a one-to-one setting. Of the remaining seven participants (who were still in treatment at the time of the interview): three felt that group therapy, one-to-one counselling and AA meetings were all important; three said group therapy; and one felt that her one-to-one sessions were most important.

The fifth category that emerged from the present study was spirituality. The 12 Step programme is well known for its spiritual nature. Step 2, *"Came to believe that a Power greater than ourselves could restore us to sanity"*, proved difficult for some participants who had to reassess their pre-conceived/current ideas of spirituality. Some participants explained how they had to abandon their pre-conceived notions of spirituality (and the 12 Step programme) as open-mindedness was paramount to their recovery. Their open-mindedness led participants to describe spiritual experiences or a spiritual awakening.

Participants' relationship with their Higher Power changed as they progressed through the treatment programme. Five out of the seven aftercare participants named God as their Higher Power. These participants felt that it was very important to have an abstract Higher Power if abstinence and sobriety were to be sustained. Interestingly of the remaining seven participants, who were still engaged with the treatment programme at the time of the interviews, only two named God as their Higher Power. One of these participants was on Step 2 and the other was on Step 3. However the remaining participants talked about their Higher Power in a spiritual way

Participants described how *Step 3 "Made a decision to turn our will and our lives over to the care of God as we understood Him."*, was about overcoming self-will and accepting their Higher Power's will. Once participants began accepting their Higher Power's will, they described a sense of a freeing relief. Step 3 was cited by the participants as paramount for their spiritual development.

The final category that materialised from the data was recovery. The 12 Step treatment model views recovery from alcoholism as a life-long process. Edwards et al (1997) supports this by stating that sobriety is usually best conceived as something built and secured over time, rather than achieved on a particular day. The programme provides the clients with the tools/strategies that enable them to achieve and hopefully maintain sobriety. However, ultimately it is the client who has to put these tools/strategies in to action.

A key concept for sustaining abstinence for this sample group was the acceptance of the disease philosophy. By accepting that they had a disease, participants recognised that they had to maintain abstinence from the substance that perpetuates the disease. This idea supports Edwards et al (1997), who argue that recovery from severe dependence almost inevitably involves acceptance of an abstinence goal. Participant talked about how they had exchanged wilfulness for willingness, admitting that they were powerlessness over the disease.

Participants cited open mindedness (re: spiritual concepts) as extremely important for their recovery. Furthermore, faith in the programme and faith in a Higher Power are paramount. This finding is supported by Twerski (1997) who explains how addicts must: (i) loose faith in their current reasoning power, and (ii) accept the possibility of another version of reality from someone they trust, in order to change their thinking and behaviour.

Participants explained how the treatment programme calls for honesty and integrity. For clients to be able to make behavioural changes (and build on these changes), they need to take an honest look at themselves. Self-awareness is the key to making changes. Clients are shown how to take a daily inventory – *Step 10, "We continued to take personal inventory and when we were wrong promptly admitted it."* One participant from the aftercare sample, explained how at the end of each day they write down what tools for recovery they used that day, asking themselves questions such as, "How did I work the program today?" or "Did I say or do anything that I need to make amends for?" This allows them to identify areas that may need more work. It also helps them identify the things that they are doing well. The daily inventory helps chart their growth in recovery. The participants have self-responsibility for becoming aware of and modifying their behaviour.

Frequently, participants talked about not knowing who they were when they stopped drinking. Participants explained how their emotional development was arrested as a result of alcohol, i.e., they stall at the age they were when they had their first drink, and

therefore treatment and recovery are part of the growing process. This is highlighted in the following quote from Knapp's (1999) memoir:

> ... in some deep and important personal respects you stop growing when you start drinking alcoholically. The drink stunts you, prevents you from walking through the kinds of fearful life experiences that bring you from point A to point B on the maturity scale... After a while you don't know even the most basic things about yourself...
>
> [Knapp, 1999, page 70]

Inevitably, participants describe how they undergo a process of building a new identity. In order for this new identity to be sustained, positive reinforcements are required in the form of experiences which demonstrate the benefits/advantages of being alcohol-free. This supports the findings of McIntosh and McKeganey (2002). They found that for an ex-addict to manage the transition from addiction to conventional life, they have to develop a range of new activities and relationships to replace those that they have given up and to reinforce and sustain their new identities. The general consensus among the participants in the present study was that changes in self usually occurred gradually and other people, such as family and friends, noticed the changes before the individual. The new identity is further substantiated by improved relationships.

Participants talked about how their AA involvement was important in sustaining their recovery. Edwards (2000) stresses the importance of establishing a personal micro-environment that supports abstinence. For many individual, groups like AA can provide such an environment. Participants' explained that the final Step involves carrying the message of hope and recovery to other alcoholics *(Step 12 "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs")*. This was important to participants as they felt they were "giving back"/repaying the help that they had received.

Constructive use of time was also cited by participants as being important for their recovery. For such a long time, alcohol had been the driving force of their lives. They had to learn to fill the void left now that they were abstinent. The use of alternate

activities is reinforced in Marlatt and Gordon's (1985) relapse prevention model where one strategy employed to try and prevent relapse involves encouraging clients to pursue non-drinking recreational activities.

All of the participants recognised that their recovery was an active rather than passive process. Participants explained that change can happen if the person is prepared to work the Steps. Humility and serenity were viewed as vital for recovery. Participants, especially those in the aftercare sample, explained how humility and serenity helped them to surrender and stop trying to fight the reality of their situation (i.e., that they are alcoholics). This ultimately led to feelings of contentment.

To prevent ambiguity, the major phases (i.e., categories) that emerged from the data have been presented separately however, there is clearly an interrelationship between them, and certain aspects within particular phases closely relate to those contained in other phases, for example see Figure 1. In situation A, the alcoholic experiences a "trampoline" rock bottom where they feel, psychologically and/or physically, that they can go no lower but then they recover. There is a non-acceptance of the disease concept although they may outwardly say they accept it. This non-acceptance coupled with a materialistic or human Higher Power puts the alcoholic in a vulnerable position regarding relapsing. Conversly in situation B, the alcoholic experiences a rock bottom or significant turning point where abstinence is seen as a lesser distress than using alcohol. While in treatment, they come to accept the disease concept and develop a relationship with an abstract Higher Power. This leads the alcoholic to surrender to the illness, i.e., alcoholism, and accept that they are powerless over alcohol and that they will not be able to drink moderately like a non-alcoholic for any sustained period.

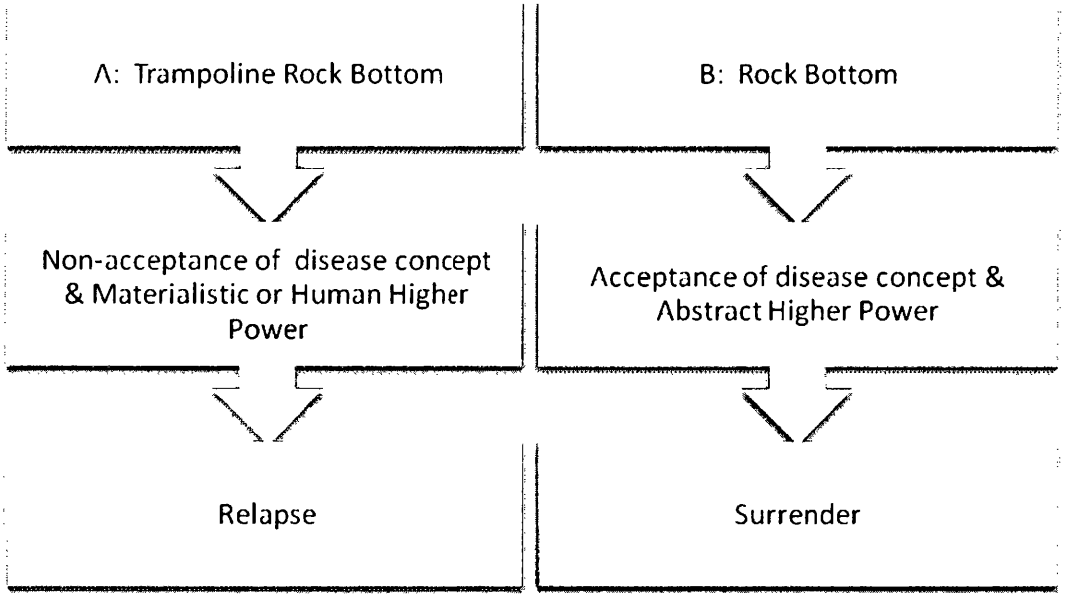

Figure 1: Processes involved in recovery.

5.3. Limitations of Study

The results of this study cannot be generalised to all recovering alcoholics for a number of reasons. The study contained a small sample of fourteen participants from a specific treatment programme. The treatment that the participants in the sample had received is likely to have influenced their experiences in some way. Also, several researchers have noted that, similar to other illnesses with a chronic and fluctuating course, treatment for alcoholism is usually sought in times of hardship and distress. Post-treatment improvements then may partly be viewed as the natural course of the disorder (Room, 1980; Vaillant et al., 1983). Furthermore, Tucker (2003) stated that among all individuals with an alcohol problem, only twenty-five percent enter formal treatment or seek help from fellowships such as AA.

The fact that this study was based entirely upon the recovering alcoholics' own accounts of their recovery may be seen as a potential problem with the research design. However, the accounts were taken to be a truthful representation of the interviewees' experience as no incentives were offered to take part in the research. They volunteered to participate in the study and they were unlikely to gain anything from being untruthful. Additionally,

as referred to in McIntosh & McKeganey (2002) study, there was a high level of commonalities between the interviewees' descriptions of their recovery. The participant interviews did not follow a structured question format that would allow for standardised comparisons between individuals. However, the methodology used is ideally suited to illuminating the context of social behaviours and the processes that underline them.

Another potential problem with this study is its reliance on retrospective data, especially with the aftercare sample who had completed treatment. These accounts may have been clouded by time or subsequent events. It is also difficult to establish causality since there is no way of determining objectively the temporality of different events and processes. However, this study was more concerned with the processes involved in recovery as opposed to the causal relationships.

5.4. Future Research

Ideally, the research design would have been longitudinal following individuals through the treatment process and interviewing them at various intervals. Under that design, as addiction for some is a relapsing disorder, the researcher would need to initiate the study with a larger cohort to allow for drop-out rates. This was not possible for the present study due to time restrictions but may form the basis for a future study. Also it would be interesting to investigate why some people are able to succeed in AA alone while others decide to access a structured 12 Step based treatment programme.

5.5. Conclusion

It has been noted that 12 Step research data has been notoriously difficult to obtain. The main difficulty being the anonymity of group members and self-selecting nature of the organisation (Bebbington, 1976, and Williams, 2002). In light of this and despite the difficulties with this study's research design; this study has provided a valuable insight, from clients themselves, on key processes in treatment that are important and successful in maintaining long-term abstinence and sustained recovery. To expand our understanding of these processes and thereby improve the way that treatment is delivered in order to reduce the serious problems that alcohol abuse can cause to

individuals, their families/friends and the communities in which they live; we need to engage in further research on a much larger scale.

REFERENCES

Alcoholics Anonymous (1988). *The A.A. Service Manual combined with Twelve Concepts for World Service*. New York: Alcoholics Anonymous World Service.

Alcoholics Anonymous (2001). *The Big Book, the Basic Text for Alcoholics Anonymous.* (4th ed.). New York: Alcoholics Anonymous World Service.

Alcohol Concern says "it's time to invest in alcohol treatment" to the Department of Health. Press release, 14th March 2006.
http://www.alcoholconcern.org.uk/servlets/doc/1086

Anderson, D.J., McGovern, J.P., & DuPont, R.L. (1999). 'The Origins of the Minnesota Model of Addiction Treatment – A first Person Account,' *Journal of Addictive Diseases*, 18(1), pp. 107-114.

B, Rosie. "In AA's 70th anniversary year, 'Rosie B' throws some light on the 12 Steps". *Drink and Drug News*, 11th July 2005, pp. 10 – 11.

Bebbington, P.E. (1976). 'The efficacy of Alcoholics Anonymous: the elusiveness of hard data,' *British Journal of Psychiatry*, 128(6), pp. 572-580.

Bess, B., Janus, S. and Rifkin, A. (1972). Factors in Successful Narcotics Renunciation. *American Journal of Psychiatry*, 128, pp. 861-65.

Biernacki, P. (1986). *Pathways from Heroin Addiction: recovery without treatment.* Philadelphia: Temple University Press.

Brownell, K, Marlatt, G., Lichtenstein, E. & Wilson, G. (1986). Understanding and preventing relapse. *American Psychologist*, 41, pp. 765-782.

Carroll, K. M., Nich, C., Ball, S. A., McCance, E. & Rounsaville, B. J. (1998). Treatment of cocaine and alcohol dependence with psychotherapy and disulfiram. *Addiction*, 93, 713-727.

Carroll, K. M., Nich, C., Ball, S. A., McCance, E., Frankforter, T. L. & Rounsaville, B. J. (2000). One-year follow-p of disulfiram and psychotherapy for cocaine-alcohol users: sustained effects of treatment. *Addiction*, 95, pp. 1335-1349.

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In R.Emerson (ed.), *Contemporary field research*, (pp. 109-126). Boston: Little, Brown.

Charmaz, K. (1990). 'Discovering' Chronic Illness: Using Grounded Theory. *Social Science and Medicine*, 30(11), pp. 1161-1172.

Charmaz, K. (2001). 'Grounded Theory', in J. Smith, R. Harre, & L. Van Lagenhove (eds.), *Rethinking Methods in Psychology*. London: Sage Publications.

Cook C.H. (1988). 'The Minnesota Model in the management of drug and alcohol dependency: miracle, method or myth?' *British Journal of Addiction*, 83, pp. 625-634(Part 1); pp. 735-748 (Part 2).

Donovan, D. M. & Wells, E. A. (2007). 'Tweaking 12 Step': the potential role of 12 Step self-help group involvement in methamphetamine recovery. *Addiction*, 102(1), pp. 121-129.

Edwards, G. (2000). *Alcohol: The Ambiguous Molecule*. London: Penguin Books Ltd.

Edwards, G., Marshall, E. & Cook, C. (1997). *The treatment of drinking problems: a guide for the helping professional*. Cambridge: Cambridge University Press.

Edwards, G., Oppenheimer, E. and Taylor, C. (1992). Hearing the noise in the system: exploration of textual analysis as a method for studying change in drinking behaviour, *British Journal of Addiction*, 87, pp. 73-81.

Elliott, R., Fischer, C.T. and Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields, *British Journal of Clinical Psychology*, 38, pp. 215-229.

Emrick, C.D., Tonigan, J. S., Montgomery, H. & Little, L. Alcoholics Anonymous: what is currently known? (1993). In B. S. McGrady & W. R. Miller (eds.) *Research on Alcoholics Anonymous: Opportunities and Alternatives*. (pp. 41 – 76). New Brunswick, NJ: Rutgers Centre of Alcohol Studies.

Frykholm, B. (1985). The Drug Career. *Journal of Drug Issues*, 15, pp. 333-46.

Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

Glaser, B and Stauss, A. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine.

Glatt, M. (1969). *The Alcoholic and the help he needs.* New York: Taplinger Publishing co. pp. 98-132.

Godfrey, C., Stewart, D. & Gossop, M. (2004). Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS). *Addiction*, 99, pp. 697-707.

Gorski, T.T. and Miller, M. (1984). *The Phases and Warning Signs of Relapse. Independence*, MO: Independence Press.

Gorski, T.T. and Miller, M. (1986). *Staying Sober: A Guide for Relapse Prevention.* Independence, MO: Independence Press.

Gossop, M. (2002). Relapse Prevention. In Peterson, T. & McBride, A. (Eds.), *Working with Substance Misusers. A Guide to Theory and Practice*. (pp. 189-196). London: Routledge.

Home Office (2002). *Updated Drug Strategy*. London: Home Office.

Jaffe, J. H. (1980). Drug Addiction and Drug Abuse. In A. G. Goodman, L. S. Gilman, & A. Gilman (eds.). *The Pharmacological Basis of Therapeutics*. New York: Macmillan Publishing Co.

Jellineck, E. M. (1960). *The Disease Concept of Alcoholism*. New Haven, Connecticut: Hillhouse Press.

Kaskutas, L. A., Ammon, L., Delucchi, K., Room, R., Bond, J. & Weisner, C. (2005). Alcoholics anonymous careers: patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research*, 29, pp. 1983 – 1990.

Kaskutas, L. A., Weisner, C. & Caetano, R. (1997). Predictors of help seeking among a longitudinal sample of the general public, 1984 – 92. *Journal of Studies on Alcohol*, 58, pp. 155-161.

Kelly, J. F. (2003). Self-help for substance-use disorders: history, effectiveness, knowledge gaps, and research opportunities. *Clinical Psychology Review*, 23, pp. 639-663.

Keso, L. & Salaspuro, M. (1990). Inpatient treatment of employed alcoholics: A randomized clinical trial on Hazelden-type and traditional treatment. *Alcoholism: Clinical and Experimental Research*, 14, pp. 584-589.

Knapp, C. (1996). *Drinking, a Love Story.* London: Quartet Books Limited.

Langley, P. (1994). *Doing Social Research: a guide to coursework.* Ormskirk: Causeway Press Ltd.

Larmier, M., Palmer, R. & Marlatt, A. (1999). Relapse Prevention: An Overview of Marlatt's Cognitive-Behavioural Model. *Alcohol Research and Health*, 23(2), 151-159.

Maddux, J.F. and Desmond, D.P. (1980). New Light on the Maturing out hypothesis in opoid dependence. *Bulletin on Narcotics*, 32, pp. 15-25.

Makela, K., Arminen, I., Bloomfield, K., Eisenbach-Stangl, I., Helmersson Bergmark, K., Kurube, N., et al. (1996). *Alcoholics Anonymous as a mutual-help movement. A study in eight societies*. Madison, WI: The University of Wisconsin Press.

Marlatt, G.A. and Gordon, J.R. (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviours*. New York: Guilford Press.

McIntosh, J. and McKeganey, N. (2002). *Beating the Dragon: The Recovery from Dependent Drug Use*. Harlow: Prentice Hall.

McKellar, J., Stewart, E. and Humphreys, K. (2003). Alcoholics Anonymous Involvement and Positive Alcohol-Related Outcomes: Cause, Consequence, or Just a Correlate? A Prospective 2-Year Study of 2,319 Alcohol-Dependent Men. *Journal of Consulting and Clinical Psychology*, 71(2), pp. 302-308.

Miles, M. and Huberman, M. (1994). *Quantitative Data Analysis: an expanded sourcebook.* (2nd ed.) California: Sage Publications.

Miller, W. (1983). Motivational Interviewing with Problem Drinkers. *Behavioural Psychotherapy*, 11, pp. 147-172.

Miller, W. (1993). Behavioural treatments for drug problems: where do we go from here? In Behavioural Treatments for Drug Abuse and Dependence. *NIDA Research Monograph*, 137, 303-21. Rockville, MD: National Institute of Drug Abuse.

Miller, W. & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to change Addictive Behaviour.* New York: Guilford Press.

Morgenstern, J., Labourie, E., McGrady, B. S., Kahler, C. W. & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: a study of its therapeutic effects and mechanisms of action. *Journal of Consultant Clinical Psychology, 65*, 768 – 777.

Moos, R. H. & Moos, B. S. (2006). Participation in treatment and alcoholics anonymous: a 16-year follow-up of initially untreated individuals. *Journal of Clinical Psychology, 62*, pp. 735-750.

Nowinski, J., Baker, S. & Carroll, K. (1992). *Twelve-step facilitation therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence.* (NIAAA Project MATCH Monograph, Vol. 1, DHHS Publication No. ADM 92-1893). Washington, DC: US Government Printing Office.

Ouimette, P. C., Moos, R. H. & Finney, J. W. (1998). Influence of outpatient treatment and 12 Step group involvement on one-year substance abuse treatment outcomes. *Journal of Studies on Alcohol*, 59, pp. 513-522.

Pidgeon, N.F., Turner, B.A., and Blockley, D.I. (1991). The use of grounded theory for conceptual analysis in knowledge elicitation. *International Journal of Man-Machine Studies*, 35, pp. 151-173.

Prins, E.H. (1994). *Maturing Out: an empirical study of personal histories and processes in hard drug addiction.* Amsterdam: University of Amsterdam Press.

Prins, E. (1995). *Maturing out: an empirical study of personal histories and processes in hard-drug addiction.* Assen: Van Gorcum.

Prochaska, J.O., DiClemente, C.C. and Norcross, J.C. (1992). In Search of How People Change: applications to addictive behaviours, *American Psychologist*, 47(9), pp. 1102-1114.

Project MATCH Research Group (1997). 'Matching alcoholism treatments to client heterogeneity: Project MATCH post treatment drinking outcomes,' *Journal of Studies on Alcohol*, 58(1), pp. 7-29.

Robbins, L. (1993). Vietnam veterans' rapid recovery from heroin addiction: a fluke or normal expectation? *Addiction*, 88, pp. 1041-1054.

Room, R. (1993). Alcoholics Anonymous as a social movement. In B. S. McCrady & W. R. Miller (eds.), *Research on Alcoholics Anonymous. Opportunities and alternatives* (pp. 167–188). New Brunswick, NJ: Rutgers Centre of Alcohol Studies.

Room, R. (1980). New curves in the course: A comment on Polich, Armor and Braiker, "The course of alcoholism". *British Journal of Addiction*, 75, pp. 351-360.

Room, R. & Greenfield, T. (1990). Alcoholics Anonymous, other 12 Step movements and psychotherapy in the US population. *Addiction*, 88, pp. 555-562.

Shaffer, H.J. (1992). The psychology of stage change: the transition from addiction to recovery, in J. Lowinson, P. Ruiz, R. Millman and J. Langrod et al. (eds.). *Substance Abuse: A Comprehensive Textbook.* Baltimore: Williams and Wilkins, pp. 100-5.

Shaffer, H.J. and Jones, S.B. (1989). *Quitting Cocaine: the struggle against impulse.* Lexington, MA: Lexington Books.

Simpson, D.D., Joe, G.W, Lehman, W.E.K. and Sells, S.B. (1986). Addiction Careers: etiology, treatment and 12 year follow up outcomes, *The Journal of Drug Issues*, 16(1), pp. 1102-14.

Singleton, N., Murray, R. & Tinsley, L. (2006). Measuring different aspects of problem drug use: methodological developments. Home Offce Online Report, 16/06. London: Home Office.

Smart, R.G. (1994). Dependence and Correlates of Change: a review of the literature, in G. Edwards and M. Lader (eds), *Addiction: Processes of Change*, Oxford: Oxford University Press, pp. 79-94.

Smith, J. A. (2001). Semi-structured interviewing and qualitative analysis. In J. Smith, R. Harre and L. Van Langenhove (eds.). *Rethinking Methods in Psychology*. London: Sage Publications.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: using Interpretative Phenomenological Analysis in health Psychology. *Psychology and Health*, 11, pp. 261-271.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre and L. Van Langenhore (eds.), *Rethinking methods in psychology*. (pp.9-26). London: Sage Publications.

Stall, R. and Biernacki, P. (1986). Spontaneous remission from the problematic use of substances: an inductive model derived from a comparative analysis of the alcohol, opiate, tobacco and food/obesity literatures, *The International Journal of The Addictions*, 21(1), pp. 1-23.

Stimson, G.V. and Oppenheimer, E. (1982). *Heroin Addiction: Treatment and Control in Britain*, London: Tavistock.

Stinchfield, R. and Owen, P. (1998). Hazelden' Model of Treatment and its Outcome. *Addictive Behaviors*, 23(5), pp. 669-683.

Strauss, A. (1987). *Qualitative analysis for social scientists*. Cambridge, UK: University of Cambridge Press.

Strauss, A. and Corbin, J. (1990). *Basics of Qualitative Research*. (1st ed.). Thousand Oaks, CA: Sage Publications.

Sussman, S. and Ames, S.L. (2001). *The Social Psychology of Drug Abuse*. London: Open University Press.

Tucker, J. A. (2003). Natural resolution of alcohol-related problems. In M. Galanter (ed.), *Recent developments in alcoholism. Research on alcoholism treatment*. Vol. 16. New York: Klurrer Academic Plenum Publishers.

Twerski, A.J. (1997). *Addictive Thinking, Understanding Self-Deception.* (2nd ed.). Minnesota: Hazelden.

UKATT Research Team. (2005) Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). *British Medical Journal*, 331:54, pp. 1-4.

Valliant, G. E. (1996). Addictions over the life course: therapeutic implications. In G. Edwards and C. Dave (eds.). *Psychotherapy, psychological treatments and the addictions*. Cambridge, UK: Cambridge University Press.

Valliant, G.E. (1983). *The Natural History of Alcoholism*. Cambridge, MA: Havard University Press.

Waldorf, D. (1983). Natural Recovery from Opiate Addiction: some social-psychological processes of untreated recovery, *Journal of drug issues*, 13(2), pp. 237-80.

Waldorf, D. and Biernacki, P. (1981). The natural recovery from opiate addiction: some preliminary findings, *Journal of Drug Issues*, 11(1), pp. 61-76.

Williams, C. (2002). Twelve Step Approaches. In Peterson, T. & McBride, A. (Eds.), *Working with Substance Misusers. A Guide to Theory and Practice* (pp.134-144). London: Routledge.

Willig, C. (2001). *Introducing Qualitative Research in Psychology. Adventures in theory and method.* Buckingham: Open University Press.

Winick, C. (1962). Maturing out of narcotic Addiction. *Bulletin on Narcotics*, 14, pp. 1-7.

Winters, K. C., Stinchfield, R. D., Opland, E., Weller, C. and Latimer, W. W. (2000). The effectiveness of the Minnesota Model approach in the treatment of adolescent drug abusers. *Addiction*, 95(4), pp. 601-612.

GLOSSARY

AA	Alcoholics Anonymous
CBT	Cognitive Behavioural Therapy
CM	Clinical Management
IPA	Interpretative Phenomenological Analysis
MET	Motivational Enhancement Therapy
NA	Narcotics Anonymous
TSF	Twelve Step Facilitation Therapy
WGCADA	West Glamorgan Council on Alcohol and Drug Abuse

APPENDIX 1: THE 12 STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we are powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to all of them.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and mediation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Source: Alcoholics Anonymous World Service (1988).

APPENDIX 2 – ETHICAL APPROVAL

PSYCHOLOGY DEPARTMENT

ETHICS COMMITTEE

Memo

To: Rebecca Hancock
From: Jackie Scholz, Secretary
(for Professor David Clark, Chair of Departmental Ethics Committee)
CC: Professor David Clark
Date: 17th December, 2002
Re: **The process of recovery from addiction**

Members of the departmental Ethics Committee have now reviewed the above study and agree that it raises no substantive ethical issues, provided the information obtained from the questionnaires is kept absolutely confidential and that no personally identifiable information is entered on computer. You may therefore proceed with your study.

A copy of this memo has been passed to your project supervisor. Together with a copy of your Ethics Application Form, a copy of this memo should be bound into the final version of the project report.

APPENDIX 3 – STANDARDISED DESCRIPTION OF THE PURPOSE OF THE RESEARCH

Description of the research study

Currently I am enrolled at the University of Wales, Swansea studying for a Masters Degree in Philosophy.

As part of my research, I am interviewing people who are in the recovery process from alcohol addiction, and engaged with a 12 Step based treatment programme. I am particulary interested in hearing your views about how addiction develops, the process of recovery and the potential role of treatment within this.

It is intended that the outcome of this study will contribute to the understanding of the psychological aspects of addiction and recovery and have clear implications for treatment and rehabilitation practice, and reduce the impact alcohol use has on the individual's life, plus those of their families and communities.

APPENDIX 4 – CONSENT FORM

Consent form

There are many ways in which people overcome their problem with alcohol. I would like to talk to you today about your life, your alcohol use and the help you have received.

Everything you say is **entirely** confidential and will not affect how you are treated in any way. I would like to tape record our conversation to assist with the analysis process if that is OK with you. Your interview will not be kept in your case notes.

If you choose not to answer any questions, that is completely fine. You are free to terminate your participation at any time.

Please sign if you are happy to participate:

Participant's signature _____

Date _____

APPENDIX 5 – SEMI-STRUCTURED INTERVIEW

1. Can you briefly talk me through the events that led to you accessing the primary treatment group?
    - How severe was your alcohol problem?
    - When did you realise you had an alcohol problem?
    - How long did it take before you accessed support/treatment?

2. Before accessing the primary treatment group, what was your involvement with the agency?
    - How long were you engaged with the agency before accessing the primary treatment group?
    - What do you feel the agency provided for you during this time?

3. How did you feel starting the primary treatment group?

4. What are/were your expectations of the primary group?

5. Why did you opt for a community-based abstinence treatment programme instead of working the programme through the fellowship?

6. How do you feel about the disease concept? Do you accept it?
    - What made it difficult for you to understand/accept?
    - What was it about the disease concept that made it easy for you to understand/accept?

7. Can you talk me through the Step you are currently on and the Steps you have completed so far?
    - What were your expectancies at each stage?
    - What were/are your thoughts and feelings regarding the individual Steps?

8. What Step, if any, has been the most important for your recovery? *(Explore processes involved.)*

9. Has your involvement with AA changed since you began the primary treatment group? If so, how?
    - How often do you attend AA?

10. Have you relapsed while accessing the primary treatment group? If so, when did the lapse occur and why?
    - What happened after the lapse?

11. What was different about stopping drinking this time as opposed to previous attempts?

12. Do you feel the treatment programme has changed you as a person?
    - In what way has the treatment programme changed you?

13. At what stage in your treatment did you notice a significant change in your way of thinking/feelings/attitudes/beliefs/behaviour?
    - In terms of you, your using, your life, family relationships…

14. Have you noticed a difference in the way people interact with you since you've been in recovery?

15. Why do you think this treatment suits/suited you?

16. How would you describe this experience of treatment to others?
    - What advice would you give to someone starting the primary treatment group?