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# A Naturalistic Investigation Into the Processes and Themes of Recovery From Chemical Dependency

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**A NATURALISTIC INVESTIGATION INTO THE PROCESSES AND  
THEMES OF RECOVERY FROM CHEMICAL DEPENDENCY**

**By**

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**OLD DOMINION UNIVERSITY  
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## **ABSTRACT**

### **A NATURALISTIC INVESTIGATION INTO THE PROCESSES AND THEMES OF RECOVERY FROM CHEMICAL DEPENDENCY**

**Mark Thomas Blagen  
Old Dominion University, 2002  
Director: Dr. Garret McAuliffe**

**The research on recovery from alcoholism and drug addiction has generally focused on the causes of relapse. Although the study of the causes of relapse is an important endeavor, the results of this focus remain inconclusive. Understanding the process and themes of recovery is also an important question that remains a significant challenge.**

**This study attempts to explain, in part, why it is that one person can have many relapse indicators and still thrive in recovery, while another who has multiple layers of support and opportunity for recovery, succumbs to addiction. This study also attempts to determine if and how the recovery process is different for participants who approach their recovery in the following three ways: 1) those who recover in a traditional manner by being professionally treated for their addiction and by using Alcoholics Anonymous or Narcotics Anonymous to support their treatment (the AA group), 2) those who were professionally treated for their addiction, but did not use AA or NA to support their recovery (the TX group), and 3) participants who spontaneously or naturally recovered without the use of treatment or the support of AA or NA (the SR group).**

**Methodology of this study was the use of a naturalistic inquiry. Seventeen participants were interviewed using a semi-structured interview format.**

**Findings of this study include the emergence of a new model of the process of recovery that was common for all 17 participants. This model included the following four phases of recovery: the Initiation Phase, the Adjustment Phase, the Relapse Phase (eight of 17 participants had experienced a relapse), and the Transformation Phase. This process of recovery and associated phases emerged from 11 recovery themes and 56 categories or topics. There was no discernable difference in quality or level of recovery based on how the participants obtained or sustained their recovery. What is different is how the transformation took place. For example, members of the TX group rejected AA or NA, but found alternate support in family, community, their faith or internal processes, or a combination of the above. Members of the SR group tended to be more self-directed, and possessed a measure of clarity that facilitated their transition from active addiction to recovery in a rather smooth manner. Finally, members of the AA group used spirituality more extensively than the members of the TX or SR.**



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## TABLE OF CONTENTS

	Page
LIST OF TABLES .....	IX
LIST OF FIGURES .....	X
<b>Chapter</b>	
I. INTRODUCTION.....	1
BACKGROUND OF THE PROBLEM .....	3
PURPOSE OF THE STUDY .....	8
LIMITATIONS OF PREVIOUS STUDIES .....	8
LIMITATIONS OF THE STUDY .....	10
SIGNIFICANCE OF THE STUDY .....	10
II. REVIEW OF THE LITERATURE .....	12
OVERVIEW OF THE CHAPTER .....	12
DEFINITIONS, MODELS, CHARACTERISTICS AND CAUSES OF RELAPSE .....	13
MODELS AND CHARACTERISTICS OF RECOVERY .....	38
NATURAL RECOVERY FROM ADDICTION .....	64
CHAPTER SUMMARY AND OVERVIEW OF PRESENT STUDY .....	70
III. METHODOLOGY .....	75
INTRODUCTION .....	75
ROLE OF THE RESEARCHER .....	76
PARTICIPANT SELECTION .....	78
INTERVIEW INSTRUMENT .....	81
DATA ANALYSIS .....	84
TRUSTWORTHINESS .....	85
IV. FINDINGS .....	87
INTRODUCTION .....	87
PROCESS AND THEMES OF SUCCESSFUL RECOVERY .....	87
INITIATION PHASE .....	89
ADJUSTMENT PHASE .....	96
RELAPSE PHASE .....	107
TRANSFORMATION PHASE .....	111
DIFFERENCES IN THE PROCESS AND THEMES BASED ON GROUPS .....	122

<b>V. DISCUSSION AND ANALYSIS .....</b>	<b>130</b>
<b>INTRODUCTION .....</b>	<b>130</b>
<b>THEORETICAL IMPLICATIONS.....</b>	<b>130</b>
<b>CLINICAL IMPLICATIONS .....</b>	<b>146</b>
<b>LIMITATIONS .....</b>	<b>156</b>
<b>SUGGESTIONS FOR FURTHER RESEARCH .....</b>	<b>158</b>
<b>CONCLUSION .....</b>	<b>160</b>
<b>REFERENCES. ....</b>	<b>163</b>
<b>APPENDICIES</b>	
<b>A. SOLICIATION LETTER.....</b>	<b>175</b>
<b>B. INFORMED CONSENT DOCUMENT.....</b>	<b>176</b>
<b>C. PARTICIPANT SCREENING FORM .....</b>	<b>179</b>
<b>VITA .....</b>	<b>180</b>

## LIST OF TABLES

Table Name	Page
1. Participant Characteristics .....	80
2. Phases, Themes and Number of Participants Experiencing Them .....	88
3. Categories for the Question “Describe the Event for Events that Created an Opportunity for your Recovery? .....	91
4. Variation by Group on Question “Describe the Event or Events that Created an Opportunity for your Recovery?” .....	92
5. Categories for Question “What were the Specific Event or Events that Significantly Impacted your Desire to Recover?” .....	95
6. Variation by Group for the Question “What Social support did you have during your First Year of Recovery?” .....	100
7. Categories for the Question “How would you Explain your Recovery When Others you know have not been Successful?” .....	112
8. Variation by Group for the Question “How would you Explain your Recovery when others you know have not been Successful?” .....	112
9. Variation by Group in Percents when Categories are Collapsed to External and Internal Factors for the Question “How would you Explain Your Recovery when Others you know have not been Successful?” .....	113
10. Variance of Themes by Group with Number of Participants .....	125

## LIST OF FIGURES

Figure Name	Page
1. Qualitative Data Reduction .....	85
2. The Multimodal Process of recovery (MPR) .....	89

# **CHAPTER I**

## **INTRODUCTION**

**Alcohol and other drug problems are among the most significant social issues this nation faces in the year 2002 and beyond. These problems do not have political, socioeconomic, or human boundaries.**

**Many societal ills have their roots in substance abuse, as illustrated by the following examples. In 1992, the annual costs of alcohol abuse were estimated at \$148 billion and other drug abuse costs at \$98 billion (National Institute on Drug Abuse & National Institute on Alcohol Abuse and Alcoholism, 1998). More than 100,000 deaths in the United States are attributed annually to the drug alcohol alone (McGinnis, & Foege, 1993). Even the AIDS epidemic is fueled by the drug problem, with over one-third of the new cases attributed to IV drug use (Center for Disease Control and Prevention, 1997).**

**Drugs are implicated in crime, with the relationship between the use of alcohol and other drugs and criminal activity being clearly established. Approximately 80 percent of incarcerated adult males were under the influence of drugs or alcohol, were engaging in illegal activity to purchase drugs, had a history of problematic drug or alcohol use, or some combination of these factors at the time they committed their crimes. Alcohol or other drugs were a factor in nearly 40 percent of violent crimes and alcohol was associated more closely with**

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**American Psychological Association (2001). *Publication manual* (5<sup>th</sup> ed.). Washington, DC: Author.**

violent crime than any other drug (Center on Addiction and Substance Abuse, 1998). Drugs also are implicated in child abuse, neglect, and domestic violence. Parents who neglect or physically abuse their children are significantly more likely to have a substance abuse or dependence disorder (Kelleher, Chaffin, Hollenberg, & Fischer, 1994). Evans (1998) reported that substance abuse disorders are involved in 89 percent of substantiated cases of child abuse involving a child under the age of 12 months. Domestic violence has a similar significant relationship. In one study, 92 percent of the assailants used alcohol or other drugs on the day of their arrest and 72 percent had prior arrests for substance abuse related offenses (Brookhoff, O'Brien, Cook, Thompson, & Williams, 1997).

Either directly or indirectly, substance abuse is the most common "disease" encountered by the modern physician (American Medical Association, 1993), yet most alcohol and/or drug abuse problems are not recognized by physicians (O'Brien & McLellan, 1997). Even though substance abuse is a major contributing factor to illness and disease, less than one percent of the typical medical school curriculum addresses alcohol or drug abuse (Selwyn, 1993).

The problem of drug and alcohol misuse is an enormous drain on scarce health resources. Over 50 percent of emergency room admissions are directly or indirectly related to substance abuse problems (Gentilelo, Donovan, Dunn, & Rivera, 1995; Evans & Sullivan, 1990). Medical treatment of alcoholism and drug addiction, combined with the various psychiatric interventions for these



disorders, accounts for up to 60 percent of hospital usage in this country (Ciraulo, Shader, Ciraulo, Greenblat, & Von Moltke, 1994).

Nearly two-thirds of the population of the United States is or will be directly affected by addiction. It is estimated that anywhere from five to ten percent, on the low side (Harvard Medical School Mental Health Letter, 1995), to 20 percent (Franklin, 1987), on the high side, of the population at one time or another is addicted to drugs other than tobacco.

These statistics suggest that many individuals are affected directly by addiction and that chemical dependency and abuse are significant societal problems. A factor that confounds this problem is that only approximately 10% of all alcoholics and addicts ever receive any formal treatment (Fletcher, 2001; Miller, Swift, & Gold, 1998). Of those who do receive treatment, it is estimated that 65% to 85% return to problematic use of psychoactive substances within the first year after treatment (Miller, Andrews, Wilbourne, & Bennett, 1998; Polich, Armor, & Braiker, 1981).

### *Background of the Problem*

This section briefly will discuss the nature of addiction and the urban influence on addiction. Understanding addiction is not difficult, although it is often misunderstood. This section discusses the multiple causes of addiction and also considers the impact addiction has on the urban core.

*The Nature of Addiction.* Who becomes addicted? Many of those who use psychoactive substances, even regularly, never become addicted, and some who initially have used psychoactive substances in a limited, social context will

progress to addiction. Researchers long have felt that the causes of addiction are complex and multi-faceted (Leshner, 1997). The concept of a unitary cause of addiction, has in general, been discounted in favor of the view that addiction is caused by a combination of biological, psychological and sociological (environmental) factors (Kissin, & Hanson, 1982).

There is a strong biological/genetic component to addiction (Anthenelli & Schuckit, 1997). Several teams of researchers have attempted to identify the degree to which the individual's genetic/biological makeup influences the development of alcohol and drug use disorders. The results of these investigations consistently reveal that 40 to 60 percent of the individual's risk of developing an alcohol/drug use disorders appears to be mediated by genetic influences (Prescott & Kendler, 1999).

But what about the other 40 to 60 percent who do not have this genetic influence, and what about the non-addicted siblings of that 40 to 60 percent who are genetically influenced? Social or environmental factors are nearly as an important factor in the etiology of addiction. A few of many important social or environmental factors that contribute to initial use, continued use, and for some, addiction to psychoactive substances include, learning or modeling from family members or other significant others (Lawson, 1992); reinforcement such as feeling good about self, life, or others (Lawson); easy access and availability (Center for Substance Abuse Prevention, 1998); and the acceptance of use by important others (CSAP).

Psychological factors may also be a factor. These factors might include the degree of psychological pain an individual is experiencing (e.g., self-medication for anxiety or depression), locus of control, and level of self-esteem (Reiger, et al., 1990).

In essence, it is an interaction of many of these risk factors that determines who becomes addicted. The more risk factors, the more likely addiction will occur. Over the life-span the influence of these factors can and do change. Late-onset alcoholism is an example of this, as is the spontaneous remission of heroin addiction in aging heroin addicts.

The best, albeit equivocal, answer to “who can become addicted” might be “anyone” and “it depends.” One specific factor worthy of consideration is the urban influence on addiction. Specifically, the relationship of the urban poor and use of psychoactive substances. Although the relationship is not empirically causal, the factors of availability, loss of hope, subculture influence do impact usage in this environment (Johnson & Muffler, 1997).

*The Urban Factors on Addiction.* Addiction occurs across socioeconomic strata, religions, and ethnic groups (Rootman, & Smart, 1985). Thus, the problem of addiction is no more an “urban” problem than crime is an urban problem, if we mean by urban, poor and minority people. And, in fact, each of the above-mentioned socioeconomic, religious, and ethnic groups seem to possess some idiosyncratic features that both exacerbate or protect them from problems associated with addiction (Goodwin, & Gabrielli, Jr., 1997). For example, those who practice the Jewish faith, due to the ritualized meaning that this faith places

on alcohol, have a relatively low incidence of alcohol abuse and as a consequence, alcoholism. This, could be viewed as an example of a culture protecting against problematic use. But this cultural norm also can complicate identification and subsequent support for those members who do develop problems related to their use of alcohol. In an urban environment, problems with psychoactive substance abuse and addiction tend to be exacerbated (Harrison, 1995).

Certain types of substance addiction are associated with the urban core environment. In the past, heroin addiction and trade were problems primarily associated with the inner city (Harrison, 1995). Although this is not as true today, there still remains an inner city association with this drug that is best illustrated in the fact that nearly half of all heroin addicts reside within New York City, and over 98 percent of all heroin addicts reside in large metropolitan areas (Harrison, 1995).

Crack cocaine use and trade also is associated primarily with the inner-city, although not to the degree that heroin is. Statistics suggest that a larger proportion of those addicted to crack cocaine reside in this environment (Kandel & Yamaguchi, 1993) although it certainly is not isolated in the inner-city. Crack cocaine, partially due to economic marketing strategies, is available in doses affordable to those with limited means, making it more marketable within the inner city and to others with lower socio-economic status.

Studies also have shown that the poorly-educated and chronically unemployed have psychoactive substance abuse problems at a higher rate and

with a poorer treatment outcome than those whose level of education is higher or whose earning ability is more stable (Humphrey, Moos & Finney, 1995; Deren, & Randall, 1990; Reichman, Levy, & Herrington, 1979). The urban environment is where many of the most poorly educated and chronically unemployed reside.

Sociological and environmental factors in substance abuse, such as availability, learning, reinforcement, strain, control, and subculture theory are evidenced and applicable within the urban environment (Fishbein & Pease, 1996). Environmental support from traditional sources also may be weaker in the urban environment (Johnson, Williams, Dei, & Sanabria, 1990). These traditional sources include close-knit and extended families and smaller, caring communities. These traditional sources are often factors that can be beneficial in rendering deterrence, intervention and assistance. And often, the financial resources of those residing in an urban environment are lacking. Inadequate resources of health insurance and the ability to pay for substance abuse services in concert with the inability of the social service infrastructure in the urban environment to adequately and effectively address the needs of the poor, exacerbates an already significant problem (Sandefur & Tienda, 1988).

Although substance abuse is not a uniquely urban problem, dimensions of the problem are uniquely urban. For those in the urban environment who are addicted, intervention and treatment are less likely to occur (Johnson, et al., 1990).

### ***Purpose of the Study***

This study, using in-depth interviewing, will attempt to answer the following two questions:

- 1) What are the processes and themes of successful recovery from chronic use of psychoactive substances, and
- 2) what are the differences in the processes and themes for the following three groups:
  - for those who were professionally treated for their addiction and use Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) to support their recovery
  - for those who were professionally treated but did not use AA or NA to support their recovery
  - for those who were not professionally treated and who did not use AA or NA to support their recovery.

### ***Limitations of Previous Studies***

The research that has been reported prior to this study primarily has been concerned with determining factors that contribute to relapse. Most of these studies have been done in the traditional, quantitative mode of inquiry.

The following are some of the typical topics and examples of studies that have reported some of the factors that contribute to relapse. Previous studies that discussed such factors as stressful life events include (Billings, & Moos, 1980), motivation for recovery (DiClemente, 1999), severe dysfunction within family of origin (Miller & Stermac, 2000), self-efficacy (Allsop, Saunders, &

Phillips, 2000; Burling, Reilly, Moltzen & Ziff, 1989; Cantrell, Meisner, Krieshok, Norman & Piedimonte, 1993), psychological stability (Svanum & McAdoo, 1989), participation in alcoholics Anonymous (Aharon, 2000; Morgenstern, Frey, McCrady, & Labouvie, 1995; Johnsen, & Herringer, 1993; Ellis, & McClure, 1992; Sheeren, 1989), negative mood (Hodgins, Guebaly & Armstrong, 1995; Stowig, 2000), and cue exposure (Rohsenow, Monti, Rubonis, Sirota, Niarua, Colby, et al., 1994; Cooney, Gillespie, Baker & Kaplan, 1987).

All of these factors have been suggested, by their authors, as central causes of relapse. Although any of these issues may be problematic for a recovering individual, they in themselves do not predispose an individual to relapse. In fact, many (if not all) recovering people possess some or many of the above-listed problems, along with many others not listed, and many of these individuals do successfully recover (Marlatt, 1985a).

Another problem with the previous research is that most of the subjects studied have been from a middle-class, suburban environment, and have been formally and professionally treated for their addiction. This research largely has excluded the urban poor. Although chemical dependency is not isolated to an urban environment, it is more pronounced there because of specific casual environmental (social) factors. Also, because of the lack of access to health care and adequate treatment options for this population, they are less likely to receive any form of formal treatment (Johnson, et al., 1990).

A related and additional problematic issue in previous studies is that few of these studies have attempted to discuss spontaneous remission or natural

recovery. Although this study only includes seven individuals who experienced spontaneous remission, this topic is worthy of consideration in any discussion of the process of recovery.

#### *Limitations of the Study*

The themes and processes identified in this study are most likely only some of the processes and themes that are germane to those who are in recovery. Recovery is a process that is loosely correlated with time. This means that two people with the same amount of time most likely will not be at the same point in recovery development. This is because the recovery process is both fluid and idiosyncratic. The identified themes and processes in this study are those that are relevant currently, or from the recoverable past of those who participated in this study.

#### *Significance of the Study*

Relapse in chemical dependency is, at best, a problematic phenomenon for the relapsing individual and for society. At worst, it is fatal for the individual and devastating to the loved ones around her or him. The issues that contribute to relapse are well studied but remain inconclusive. As with addiction, relapse is caused by a complex cluster of variables that are interrelated with each other (Gorski, 1990). The study of the cause of relapse remains important and a worthwhile endeavor. Perhaps as important, is understanding the themes and processes of successful recovery. Understanding both the causes of relapse and the processes and themes of recovery will greatly assist, chemical dependency professionals, program managers and policy makers in developing treatment



**programs that incorporate this knowledge to assist recovering individuals in their pursuit of successful recovery. This study also will add to the sparse literature on spontaneous recovery. By understanding the themes of traditional recovery and natural recovery, chemical dependency professionals and others can assist addicted individuals with the recovery process. Identification of these themes and processes also will lead to further investigation and additional theory building.**

## **CHAPTER II**

### **REVIEW OF THE LITERATURE**

#### *Overview of the Chapter*

**This chapter will review the literature related to the process and themes of successful recovery from addiction and is organized into three sections. All three sections are germane to the current study and include characteristics and models of relapse, characteristics and models of recovery, and research related to the topic of spontaneous recovery.**

**The first section will review the literature related to the topic of relapse. A relapse, or an uncontrolled return to alcohol or other drug use following competent treatment, is one of the greatest problems substance abusers and their counselors face (Lewis, Dana & Belvins, 2002). Polich, et al. (1981) and Miller, Swift, et al. (1998) have reported that close to 80% of all clients treated for substance abuse relapse within 1 year after their discharge from treatment. The first obstacle for the recently abstinent alcoholic or drug addict is to avoid relapses.**

**Although avoiding relapse is essential for recovery, it does not ensure recovery (Brown, 1985; Gorski, 1990). Recovery is a process that includes various tasks. Successful completion of these tasks assist the abstinent individual in the substantial change process that is the hallmark of long-term recovery (Diclemente, 1999). Although relapse is much more likely to occur in the first year of recovery, relapse can occur at any time. Section two reviews the**

**literature and models related to the processes and themes of successful recovery.**

**Does recovery occur naturally without the aid of professional treatment or the use of AA or NA for support? Nearly all of the research into the recovery process has been done with individuals who have been professionally treated for their addiction, and in most cases, individuals who have used traditional means of AA or NA to support their recovery. Recently, research has begun to suggest that there is a large percentage of individuals who are successful in recovery, who never received treatment or who rejected traditional methods of recovery (Smart, 1975/1976; Goodwin, Crane, & Guze, 1971; Sobell, Sobell, Toneatto, & Leo, 1993; Peele, 1989). The third section of this chapter will review the literature related to this topic. This topic is relevant to the current study in that over two-thirds of the participants of this study were never treated for their addiction or who rejected traditional methods of recovery.**

#### ***Definitions, Models, Characteristics and Causes of Relapse***

**Relapse is operationally defined in this research as the return to the use of a psychoactive substance (other than nicotine) or to a substitute addiction such as the compulsive use of food or other dysfunctional patterns of compulsive behavior after a period of abstinence that was based on accepting their addiction (Gorski & Miller, 1986). This definition suggests several important features of relapse. The first, which differentiates it from a simple period of abstinence, is that, during this period of abstinence, the individual has accepted his or her addiction and made progress toward moving away from addictive behavior. The**

**second important feature is that relapse occurs either when a person returns to their primary drug or when he or she returns to any dysfunctional pattern of compulsive behavior. This is known as substitute addiction.**

**Although nicotine is considered to be a drug of abuse, concurrent nicotine dependence is common among users of alcohol and other drugs, with prevalence ranging from 85 percent to 100 percent (Burling, & Ziff, 1988; Difranza & Guerrera, 1990; Istvan & Matarazzo, 1984). Most individuals who are in recovery have a tendency not to address their nicotine addiction until later in their recovery, if at all (Difranza & Guerrera). Thus, finding participants for this study who do not use nicotine would have been much more difficult.**

**What causes relapse? A thorough review of the literature suggests that the causes of relapse vary. As with what causes addiction and what seems to get a person into treatment, there are multiple causes working in concert that impact individuals in different ways. In general, it seems that three important factors contribute to relapse. These are, a lack of motivation to sustain recovery (the benefits of the drug use out weighs the deficits), a belief that meaningful recovery for them is not possible, and the lack of positive social and environmental support to remain abstinent (Lawson, Lawson & Rivers, 2001). The models and characteristics of relapse discussed below consider these three factors, and others in more detail. The following is a selected review of the relevant literature related to the causes of relapse and models of relapse. This section is divided into the following two parts, 1) models of relapse, and 2) characteristics of relapse.**

### ***Models of Relapse***

**A helpful way of looking at the causes of relapse is to conceptualize the causes into the following models: environmental, behavioral, cognitive, affective, and relational (Stevens & Smith, 2001). It must be noted that each model has common elements and often overlap with each other to cause a relapse incident. The studies cited in the introductory chapter and reviewed in this chapter fit into one or more of these models.**

***Environmental Model.* The *Environmental Model* of relapse addresses such factors as people, places and things that are high-risk for the recently abstinent addicted person. One of these factors is stress. Stress is the natural enemy of early recovery from addiction. Change of any kind, for most people, is stressful. The change required to transition from active addiction to abstinence requires immediate and radical change, thus creating an enormous amount of stress. Pain and stress are often cited as negative feeling states that a drug addict or alcoholic will attend to by using their drug of choice (George, 1990; Lewis et al., 2002). In the transitional period between active addiction and more stable recovery (often referred to as early recovery (Gorski, 1990)), the newly recovering person will be tested by stress. To be successful, this individual must learn, and put into practice, new ways of dealing with pain and stress. The more supported and protected the individual is during this phase the more likely they will be able to make this difficult transition successful (Lewis et al.). The transitional period usually is marked by some form of formal treatment. During the treatment process, most drug addicts and alcoholics feel empowered and**

believe that they can stay clean and sober once their treatment is over (Burling et al., 1989). This belief quickly changes once he or she return to a more typical, post treatment, environment. An addicted person's environment after treatment often is littered with obstacles that they will encounter and must successfully learn to overcome if they are to maintain their abstinence and commence recovery.

It is not difficult to explain why relapse is so common in the first 90 days of post-treatment (Cummings, Gordon, & Marlatt, 1980). Stress related to environmental factors is an important issue when considering the causes of relapse.

Other environmental issues include places and things. Specifically, Annis (1986) states that situations in which the drug addict or alcoholic used in the previous year represent a high-risk (stressful) situation. This relates to the issue of psychological craving which often results from encountering a situation that was related to drug or alcohol use. Often cited examples might be finding rolling papers that were used to roll marijuana, hearing a song that was usually listened to while high, driving by a bar that was frequented, or seeing a syringe or razorblade and mirror (Annis). These are often referred to as "triggers" or "cues." A trigger is a stimulus that has been repeatedly associated with the preparation for, anticipation of, or the use of alcohol or drugs (Rawson, Obert, McCann, & Marinelli, 1993).

Social pressure is another environmental factor that causes 20 percent of all relapses (Marlatt & Gordon, 1985). In these situations individuals respond to

the influence of another person or group of people exerting pressure on them to engage in the taboo behavior. Several of the studies reviewed in this chapter are germane to this model.

***Behavioral Model.*** Related to the environmental model is the *behavioral model*. Numerous studies have emphasized the importance of teaching clients alternative coping skills to deal with the pain and stress of every day life and the negative emotions these cause (Hawkins, Catalano & Wells, 1986; Marlatt, 1985b). Annis and Davis (1991) state that it is important to teach the client new decision-making skills. In their model is the recognition that relapse is a process and that it is the small decisions that often lead to the crisis of resuming the use of their drug of choice, taking some other psychoactive substance or engaging in a compulsive behavior. To avoid this crisis, the newly recovering drug addict or alcoholic must learn to critically question even the small decisions that they make (Cummings et al., 1980).

Negative feeling states will be common in early recovery, and for some drug addicts and alcoholics, the norm. During their chronic use of drugs and alcohol, addicted persons managed negative feelings states by using their drug of choice. Treatment does an excellent job of convincing the drug addict or alcoholic that this is a self-destructive coping mechanism and that these negative feeling states must be managed through the use of self-protective coping mechanisms. The limits of this approach are obvious: The recently clean drug addict or alcoholic usually has years of experience of dealing with pain and stress with his or her drug of choice. Although most treatment programs coach

the client in the use of more self-protective strategies, most clients are not well-practiced when they leave treatment and what exposure they did get was under circumstances quite different from the “real” world that they are now in.

*Cognitive Model.* Closely related with the environmental and behavioral model is the cognitive model. The cognitive model suggests that what we think dictates our emotional state as well as our behavior. To change how we feel and behave, we must change how we think.

The early recovery period is plagued by an emotional roller coaster. Practitioners often speak of the “pink-cloud syndrome” of those leaving treatment. This is typified by thinking that is not grounded in reality – that no matter what the problem is, it will work out in a satisfactory manner. Another term for this is unbridled optimism. The expectations of this, cannot be met and the result is a rather stark backlash of pessimism.

Recovering drug addicts and alcoholics often speak of their early days of sobriety as one minute of belief that they can stay sober or clean, followed by the opposite belief that there is no way that they will be able to maintain their sobriety. Such things as the person's attitude toward sobriety (Chalmers & Wallace, 1985), perception of their ability to cope or self-efficacy (Annis, 1986), and expectation of relapse (Annis & Davis, 1991) are important factors that contribute to relapse. The recovering communities of Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) long have understood the connection between thoughts and behavior and often speak of “stinking thinking” as contributing to relapse (Alcoholics Anonymous, 1976). Many treatment practitioners and



members of AA and NA place much emphasis on monitoring thoughts carefully to guard against negative thoughts to protect from self-destructive behavior.

Although it is expected that there will be many early recovery problems that most individuals would find difficult to deal with, it is not the problems themselves that are the precursor to relapse, but instead, how these problems are interpreted by the individual. The recovering community often will refer to these obstacles as “growth opportunities,” as opposed to something with a more negative connotation. In other words, they suggest that we are what we think.

*Affective Model.* But what about the negative and positive feeling states that do not seem to have a cognitive origin? These too are cited (Hatsukami, Pickins, & Svikis, 1981; Pickins, Hatsukami, Spicer, & Svikis, 1985) as the precursors of relapse. Negative emotional states cause 35 percent of all relapses (Marlatt and Gordon, 1985). In these situations, individuals experience negative emotional states, moods, or feelings such as frustration, anger, anxiety, depression, or boredom.

Depression and anxiety are common feeling states in early recovery and for many drug addicts and alcoholics these moods preexisted their problematic use of drugs and alcohol (Marlatt, & Gordon, 1985; Gorski, 1990). Those who are successful in recovery learn early that these feeling states are neither good nor bad, but can lead to negative behavior if not understood and mediated. For example, when a recovering person identifies a feeling state such as boredom, they are encouraged to take responsibility for that feeling state and do something about being bored – they are empowered to take action.

**Another example of these feeling states is feeling sorry for one's self. This often is referred to as self-pity. A person in early recovery will learn that the positive, opposite side of feeling sorry for self is the feeling state of gratitude. The alternative to take when feeling sorry for one's self is to focus on the numerous things the person has to be grateful for. The goal of this, is to mediate the negative feeling state with a more positive one.**

**During active addiction, the individual routinely mediates feeling states, both positive and negative, with drug use. In early recovery these feelings first must be identified, then mediated in a more self-protective manner. Not doing this often will result in feelings of guilt and ultimately shame which frequently will culminate in a relapse episode (Marion & Coleman, 1991). Multiple stress management techniques and assertiveness training are important skills that the newly recovering individual should learn to prevent relapse by mediating their positive and negative feeling states.**

***Relational model.* The last model to be discussed is the relational model. In the progression of substance abuse, relationships between the substance abuser and those in their environment become strained. Although those in the work environment tend to be the last relationships to be jeopardized, they too are often problematic. In early recovery, the stress related to these relationships is significant.**

**The newly recovering individual also must develop a new social support system. In the active stage of addiction, other drug addicts or alcoholics were their primary support system. In recovery, that support system has lost its**

**viability. In other words, the newly recovering drug addict or alcoholic is left struggling to find a new support system. Establishment of adequate social support is an important task of early recovery.**

**The lack of a supportive family or social network has been correlated highly with a return to substance use (Daley, 1987; Hawkins & Fraser, 1987; Miller, 1992; Zackon, McAuliffe & Ch'ien, 1985). Substance abuser's families have been impacted negatively and have developed methods of shielding themselves from the hurt and abuse of the addicted member. These methods often make reconciliation difficult and, in fact, for normal family functioning to reestablish itself, formal intervention may be necessary for the family as well. Due to family dynamics and other factors, intervention or treatment for the family seldom is initiated. Extremely strained family relationships are the norm for the person in early recovery. Families who do become involved in their own recovery, support the recovery of the addicted individual much more appropriately and are much less likely to sabotage the recovery process of the addicted person (Daley & Marlatt, 1992).**

**Interpersonal conflict has been cited as causing sixteen percent of all relapses (Marlatt & Gordon, 1985). These situations involve an ongoing or a relatively recent conflict associated with an interpersonal relationship, such as marriage, friendship, relationship with family members, or employer-employee relations. Arguments and interpersonal conflict for the individual in early recovery is common and stressful.**

**Summary.** The preceding models discussed suggest that relapse can occur as the result of a number of factors. These factors include social pressure and being in “high-risk” situations. They also include the lack of social support and the inability to cope effectively with the ups and downs of life. The models illustrate the difficult transition from active addiction to sustained recovery. In the following section several empirical studies are reviewed that further assist in understanding the causes of relapse.

### ***Selected Studies on the Causes of Relapse***

This section narrows the focus of the causes of relapse to studies that consider the following four factors 1) aftercare and AA or NA participation to support recovery (Fleming and Lewis, 1987; Mclatchie, & Lomp, 1988; Knouse, & Schneider, 1987; Aharon, 2000), 2) exposure and reactivity to drug using stimulus (Cooney et al., 1987; Rohsenow, Monti, Rubonis, Sirota, Niaura, Colby, et al., 1994), 3) negative mood and stressful events (Stowig, 2000; Svanum & McAdoo, 1989; Schonfeld, Rohrer, Dupree, & Thomas, 1988), and 4) self-efficacy (Cantrell et al., 1993; Burling et al., 1989; Allsop et al., 2000; Bradley, Gossop, Brewin, Phillips, & Green, 1992). Certainly, these are not all of the cause of relapse, but they are representative of the major causes and reflect aspects of the models just reviewed.

***Aftercare, AA, and NA Participation as Predictors of Relapse.*** The following are several empirical studies that have attempted to predict relapse. The factors studied include, AA/NA participation and aftercare involvement. Although regular attendance in AA or NA does not guarantee an individual will

remain abstinent, attendance at these meetings does provide support that most recovering individuals need in early recovery. The same general statement can be made concerning aftercare. Involvement in aftercare and AA or NA is generally helpful, and reflective of motivation, and thus predictive of remaining abstinent.

The goal of an aftercare program is to maintain gains made in the formal treatment process and to help prevent relapse to active chemical use/abuse (McKay, McLellan, Alterman, Cacciola, Rutherford, & O'Brian, 1998). The aftercare program is designed and carried out on the assumption that treatment does not end with the individual's discharge from a formal treatment program. Often, AA or NA attendance is considered to be a form of aftercare (Doweiko, 2000) however, many aftercare programs incorporate weekly or bi-weekly group counseling sessions with AA or NA participation. One study that illustrates the relationship between aftercare participation and relapse was done by Fleming and Lewis (1987). These researchers compared two groups of alcoholics that possessed similar personality factors based on the Eysenck Personality Inventory and the 16 Personality Factor. The two study groups were composed of 25 participants each. One group had dropped out of a two-year aftercare program and the other group had completed this program. The researchers found there was significant correlation between members of the drop-out group and the relapse rate. The "drop out " group had a 68 percent relapse rate as compared to the "completed" group which had a relapse rate of 27 percent. The

**“drop out “ group also had a higher level of self-reported marital instability, and unemployment.**

**In another study supporting the efficacy of aftercare, specifically AA, McLatchie, & Lomp (1988) followed 173 consecutively admitted patients to a one-month alcohol rehabilitation treatment program for the full 12 months of their aftercare. This aftercare program was based primarily on AA participation. Prior to treatment, these patients completed a Life History Questionnaire, an inventory of alcohol consumption (an assessment of degree of addiction), and the Freedberg-Mclatchie Card Sort (which measures degree of impairment in expressive behavior, interpersonal relationships, sexual behavior, marital relations, social and leisure activities and employment). The researchers did not find a significant relationship with treatment outcome (relapse) and any variable other than the regular use of AA participation.**

**Further demonstrating the link between aftercare activities and treatment outcome was a study, done by Knouse and Schneider (1987). This study investigated “the relationship between personality factors (depression, anger, assertiveness), aftercare activities, demographic variables, and maintenance of sobriety” (p.596). The authors received questionnaires from 262 individuals who were recovering successfully (abstinent from the abuse of mood altering substances) following their completion of a 28-day inpatient treatment program for alcoholism. The subjects had been out of the treatment program for an average of 15.8 months. Among the results the authors found was that continuously sober individuals reported 17.3 AA meetings per month while**

individuals who relapsed reported 7.2 meetings per month. Further, they found, by using step-wise multiple regression, that sobriety was correlated positively with being employed, working the AA steps, showing marital stability and being involved in a an aftercare program designed to work with the recovering individual and his or her family members.

Employing a prospective methodology, Aharon (2000) also showed the importance of aftercare participation and positive treatment outcome. This study conducted a, three-month follow-up of 228, mixed-substance, mixed gender sample of substance-abusing clients who entered a private addiction rehabilitation hospital for residential treatment. The goal of this study was to predict recovery status and use of addiction-specific supports such as aftercare and AA and NA at the three-month follow-up point. Three months was chosen as the study point since it is speculated that over half of all relapses take place in the first three months after treatment (Cummings et al., 1980). Psychological and social support factors were tested. The psychological factors examined were alexithymia (difficulty in identifying and verbally describing feelings) as measured by the revised Toronto Alexithymia Scale (TAS-20); optimism, measured by the Revised Life Orientation Test (LOT-R); and beliefs regarding the disease versus the free-will models of addictions, as measured by the Addiction Belief Scale (ABS). The use of social support groups was used both as a potential predictor of recovery status and as an outcome variable. The most striking finding of this study was the fact that all of the clients who attended the aftercare program regularly or both aftercare and 12-step groups combined were in "high" recovery

(abstinent or highly improved) during the first three months post treatment. Attendance in AA groups alone also was associated significantly with recovery status at three months. In addition, two of the three psychological variables (alexithymia and addiction beliefs) were associated significantly with level of aftercare use, thus with "high" recovery.

*Cue exposure or reactivity as a relapse predictor.* Social learning theory models of alcohol relapse (Abrams, & Niaura, 1987; Marlatt, 1985a; Monti, Rohsenow, Abrams, & Binkoff, 1988) state that risk for relapse is predicted to be associated without positive expectations about alcohol. Models of relapse based on conditioning theory (Niaura, Rohsenow, Binkoff, Monti, Pedraza, & Abrams, 1988) suggest that alcoholics may have classically conditioned responses to alcohol use cues and that exposure to these cues may increase the risk of relapse. In other words, a drug addict and alcoholic who associates positive expectations with their drug of choice is at risk of relapse. Also, exposure to drug related cues such as a beer commercial on the television, or the sight of drug using friends also will increase the risk for relapse.

The following two studies investigated both expectation and cue reactivity. These studies suggest, that in alcoholics who were recently treated for alcoholism, expectation and cue reactivity are correlated with relapse episodes.

The purpose of this first study was to examine the effects of alcohol cue exposure on the thinking and affect of abstinent alcoholics and nonalcoholic drinkers (Cooney et al., 1987). Using an alcohol stimulus, responses of forty-nine alcoholics were compared with the responses of 26 nonalcoholic drinkers.



Changes in desire for alcohol were assessed by asking subjects to rate their desire to drink from not at all (1) to very much (5) on a 5-point scale. Subjective anxiety was rated from “*definitely not anxious*” (1) to “*definitely anxious*” (5) on a 5-point scale. Self-reported physical symptoms were assessed by combining 5-point ratings of the severity of hands and fingers shaking, sweating more than usual, and heart beating faster than usual. Global expectations of pleasant alcohol effects were assessed by combining two 5-point ratings of the questions “Would you find the taste of an alcoholic drink pleasant?” and “Would you find the immediate effects of an alcoholic drink pleasant?” Expectancies also were assessed using the Alcohol Effects questionnaire, consisting of 37 bipolar adjective pairs yielding three dimensions of expectancies: stimulation/perceived dominance, pleasurable disinhibition, and behavioral impairment. On this scale subjects rated the expected effects of “enough alcoholic drinks for you to feel the effect.”

On each of three trials, participants were exposed to a control stimulus (cedar chips) or a favorite alcoholic beverage in the manufacturer’s bottle. At the end of each trial, subjects were instructed to place the bottle back under the opaque container and complete a brief questionnaire on craving, anxiety, physical symptoms, global expectations of alcohol effects, and confidence.

Results indicated that both alcoholic and nonalcoholic subjects showed the following changes after alcohol cue exposure: increased desire to drink, increased expectations of pleasant alcohol effects, decreased expectations of arousal, and decreased expectations of behavioral impairment from drinking.

**Alcoholic subjects responded to alcohol cues with reports of increased physical symptoms, decreased confidence about coping with future temptation, and increased guilt. This study showed that the sight and smell of alcohol will alter the thought process of both alcoholic and non-alcoholic participants. However, the impact on alcoholic participants also included factors that could make relapse more likely.**

**The purpose of the following similar study was to determine if conditioned responses increased the risk for relapse for male alcoholics (Rohsenow et al., 1994). Participants were selected from a group of men who were hospitalized for alcohol detoxification. Patients were told that the study was to investigate reactions to alcohol. In the screening process, potential participants were told that they would be asked to hold and smell an alcoholic beverage, but that they would not be allowed to drink it.**

**Cue reactivity assessment involved the patients sitting in front of two opaque pitchers at a table adjacent to a one-way mirror and speaker. Under one pitcher was a glass and commercially labeled bottle of spring water. Under the other pitcher was a commercial container and glass of the patient's most frequently consumed alcoholic beverage prepared the way he would normally drink it . Subjects were asked to sniff, alternately, the water and then the alcohol beverage as signaled.**

**Salivation would be determined by weighing, after the trial, three dental cotton rolls that had been placed in their mouth before each trial. Also after each trial, participants would be administered a self-report measure using a ten-point**

Likert scale to determine their urge to drink. They also were administered the Sensory Awareness Scale to determine their experience concerning 11 somatic sensations.

At 90 days, a follow-up interview and data were obtained. Each alcoholic was interviewed only after breath analysis had confirmed that his or her blood alcohol level was zero. A significant other was interviewed at the same time to provide confirmation of the interview data. During the follow-up interview, the participants also were asked to rate on a ten-point scale the urge to drink they would experience in 12 different alcohol exposure situations that can occur in their natural environment. These exposure situations included such things as seeing an ad for alcohol, seeing someone drink, or passing a liquor store.

The results showed that alcoholics who salivated more to alcohol during detoxification had a higher frequency of drinking days during the following three months. The results also showed that alcoholics who are more physiologically reactive to alcohol stimuli have worse drinking outcomes. Also, alcoholics who attended more to the alcohol cues, thought about drinking more, or who were more aware of their physical reactions in the presence of alcohol had more abstinent days than did alcoholics who avoided attending to the stimuli or to their responses.

*Negative mood and stressful events.* The relationship between negative mood (primarily depression) and relapse is well documented (Marlatt, & Gordon, 1985; Hatsukami, Pickens, & Svikis, 1981; Pickins et al., 1985). Often these negative moods are precipitated by stressful (or painful) events (Billings, & Moos,

1980; Strowig, 2000). The following studies investigate the relationship between stressful events and negative mood as a predictor of relapse.

Strowig (2000) examined relapse determinants reported by men treated for alcohol addiction in a residential setting. The study participants were 93 men treated for alcohol addiction. These men had responded to the treatment center's relapse questionnaire, had reported relapse within the first 12 months after treatment, and had endorsed one relapse determinant most directly related to their first use of alcohol or illicit drugs since program participation. Participants were predominantly middle-aged males from middle-class backgrounds.

The primary finding from this study was that participants most consistently reported relapse determinants of an intrapersonal nature. The relapse determinant most frequently endorsed was depressed mood. Depressed mood was endorsed by slightly more than one fourth of the study's participants. Most of those who expressed a depressed mood also indicated that high-risk (stressful) events were connected directly with depressed moods.

Another study with similar results was completed by Svanum & McAdoo (1989). Study participants were 575 persons who were treated in a 3-4 week residential treatment program for alcoholism and other chemical dependencies. Within the first two weeks of treatment, all patients were administered the Minnesota Multiphasic Personality Inventory (MMPI), the Alcohol Dependence Scale (ADS) and the Alcohol Problems Questionnaire (APQ), which measures alcohol-related consequences across a wide array of areas.

At three months post-treatment, the patients were contacted by telephone and administered a 20-40 minute semi-structured interview. Participants were asked about alcohol and drug use practices, aftercare involvement, and current levels of adjustment across different areas of functioning. Using information obtained from this semi-structured telephone interview, 52 subjects were identified as rapid relapsers and were determined to be clear treatment failures.

Each of the rapid relapsers was matched with a short-term treatment success on the basis of scores obtained on the 13 validity and clinical scales of the MMPI. These pairs were further designated, as psychiatric or nonpsychiatric based on MMPI profiles.

For the nonpsychiatric group, the most important factor that emerged, in relation to relapse, was continuation of a program of exercise. This variable was highly correlated with other variables measuring compliance with the aftercare plan. Persons who reported a program of continued exercise also reported more frequent AA contact, continuation in aftercare groups, and continued treatment center contact. Although compliance with the aftercare plan proved prognostically important for the nonpsychiatric group, such factors did not emerge as important for the psychiatric group. Rather, continuing emotional turmoil predicted treatment failure for this group more than for any other variable.

The following study also investigated the role of mood in predicting relapse, but the participants in this study also included females. The purpose of this study was to determine the role of mood for both male and female recovering alcoholics in their relapse and to compare prospective (before the

relapse) and retrospective (after the relapse) report of mood states. Participants were assigned randomly to one of two conditions: 1) a retrospective condition in which participants were interviewed face-to-face initially and at three, six, and 12 months and by telephone at nine months and 2) a prospective condition in which participants, in addition to the aforementioned interviews, provided a weekly telephone report for the past few days. Weekly telephone contact was continued for six months or until the resolution of the participant's first major relapse.

The findings of this research were consistent with previous research that found that negative mood states are the most frequent precipitant of relapses across a range of substances of abuse. Overall, negative emotional states accounted for 53 percent of relapses. Interesting differences also were found between major relapses and minor relapses (designated as a lapse vs. relapse). Negative mood states are more likely to cause a relapse, while social pressure is more likely to cause a lapse. Also, gender differences were noted. Women were more likely to cite interpersonal conflict as the cause of their relapse, whereas men were more likely to cite intrapersonal negative emotional states. There was not a significant finding for differences between the retrospective and prospective groupings.

The last study in this section was conducted by Schonfeld et al. (1988). This study investigated determinants of relapse and antecedents of recent use for 30 substance abusers re-entering inpatient treatment. A unique aspect of this study is that it considered the determinants of relapse to any psychoactive substance, not just to the individual's drug of choice. As an example, an alcoholic

may experience a negative or positive stressor and then use cocaine, or marijuana, purposely staying away from their drug of choice. This individual will then soon complete the relapse by resuming their use of alcohol.

Subjects were selected to participate if they entered the treatment facility during the three month period over which the study was conducted, had at least one previous inpatient treatment for alcohol abuse prior the current admission, and agreed to participate. Twenty-five males and five females met the selection criteria.

A Substance Abuse Relapse Profile (SARP) was developed for this study. This profile had three sections. The first section asked participants to describe as much detail of the surrounding post-treatment relapse event as possible. The second section focused on recent use of substances preceding admission to the current treatment. Section three included reasons for returning to treatment, explanations as to why the previous treatment did not work, and quality of life indicators such as employment, social, medical, etc. problems.

Consistent with previous research, the lapse or initial use, which often led to a complete relapse, occurred about two months after treatment, but on average, participants did not re-enter treatment until three years after their previous treatment. Generally, participants relapsed with their drug of choice. Determinants of substance abuse relapse were a mixture of interpersonal and intrapersonal events. However, during recent use (just prior to readmission to treatment), there was a dramatic shift to intrapersonal determinants considered

negative emotional states such as loneliness, nervousness, depression and anxiety.

*Self-efficacy or expectancies.* Self-efficacy is a person's belief that she or he can respond effectively to a situation by using available skills. A growing body of evidence in the addictions field confirms that the development of self-efficacy is associated with a positive treatment outcome (Annis & Davis, 1991; Coelho, 1984; DiClemente, 1981; Marlatt & Gordon, 1985).

One study tested the Gorski (1990) model of relapse prevention to determine if teaching this model increased self-efficacy (Cantrell et al., 1993). The Gorski model was designed to assist alcoholics in recognizing their relapse signs and symptoms and to act proactively.

A total of 43 patients were selected and completed pre and post treatment Self-Confidence Questionnaire's (SCQ's). These participants were contacted by telephone and mail one year post-treatment for follow-up. Questions were asked about relapse, high risk situations leading to relapse, length of sobriety, and attendance in outpatient recovery activities.

The Gorski model of relapse prevention appears to contribute to increased self-efficacy in effectively managing relapse related high-risk situations. The post-treatment total efficacy score was able to predict whether or not a participant relapsed, but that result was inconclusive in light of the small number of non-relapsers. The most interesting finding from the study is the set of relationships between level of outpatient recovery activities and relapse outcomes. Consistent with other findings from numerous prior studies, more



**intense involvement in recovery activities was associated with better outcome, (i.e., more months of sobriety).**

**Burling et al. (1989) investigated the relationship between how self-efficacy improved during the course of treatment and treatment outcome. For this study, monthly ratings of self-efficacy to avoid drug and alcohol abuse were examined among 419 substance abuse inpatients. Post-treatment interviews were conducted with 81 non-randomized selected participants at six months following discharge.**

**As expected, self-efficacy increased during treatment and was higher among abstainers than relapsers at follow-up. An interesting result was that low self-efficacy at intake was related to longer inpatient residence and more positive conditions of discharge. Furthermore, abstainers had slightly lower self-efficacy scores than relapsers at intake and increased their self-efficacy two-fold over that of relapsers during the course of treatment. Contrary to expectation, self-efficacy ratings at the end of treatment were not related to abstinence at follow-up. In other words, it was the amount of positive change in self-efficacy during treatment that predicted abstinence as opposed to the level of self-efficacy at discharge.**

**Further demonstrating post-treatment self-efficacy as a predictor of treatment outcome was a study done by Allsop et al. (2000). The purpose of this study was to investigate factors thought to influence the relapse process with a focus on self-efficacy, severity of alcohol dependence, and cognitive functioning. Participants were assessed prior to treatment, at the immediate conclusion of**

treatment and at a six and 12-month follow-up. Participants were 60 male alcoholics with high levels of alcohol dependence and alcohol related harm.

The independent variables were post-treatment self-efficacy, alcohol dependence, cognitive functioning, level of depression, and alcohol consumption prior to admission to treatment. The dependent variables were post-treatment drinking behavior and functioning and time to lapse and relapse.

Higher post-treatment self-efficacy predicted better outcome at the six-month follow-up and was associated with a reduced risk of lapse and relapse over the 12-month follow-up. Poorer cognitive functioning was associated significantly with being categorized as a problem drinker at six-month follow-up and with higher risk of a lapse over the 12-month follow-up. Level of alcohol dependence was not predictive of outcome.

The last study in this section to be reviewed has to do with the related subject of attribution as a predictor of relapse (Bradley et al., 1992). Attribution means the level of importance assigned. This study was looking at the importance assigned to self-regulated outcome. Specifically, this study investigated the attributions of opiate addicts and the ability to abstain from future opiate use. The hypothesis of this study was that opiate addicts who showed a generalized tendency to accept responsibility for negative outcomes and who attributed relapse episodes to unstable, specific, and controllable factors should have a better outcome following treatment.

This study followed 80 (60 men and 20 women) opiate addicts who were admitted to an inpatient unit for detoxification and treatment for opiate addiction.

Follow-up took place six months after treatment. Early in treatment, but after detoxification, each participant was administered the Responsibility for Positive Outcome (RPO) and the Responsibility for Negative Outcome (RNO) measures. These measures were designed to measure the amount of attribution each client possessed for both negative and positive outcomes.

At follow-up, 75 of the original 80 were located and participated. Of the 75 participants, 33 percent reported daily opiate use, 15 percent reported occasional opiate use, 32 percent reported abstinence but having used since discharge, and 20 percent reported no use since discharge.

The results indicate that beliefs concerning negative rather than positive outcomes are relevant to predicting outcome. The finding that addicts who report greater personal responsibility for negative outcomes in general have a better outcome is consistent with previous research. Addicts who perceived that they had more personal control over past or future relapses were more likely to remain abstinent and to contain the effects of brief relapses.

*Summary.* Relapse frequently is caused by several factors working in concert with each other. It can not be overemphasized that successful recovery from addiction is extremely difficult because it requires an individual to make abrupt and radical change. Any change is stressful, but the abrupt and radical transformation required for successful recovery is extremely stressful. A drug addict's and alcoholic's primary coping mechanism for dealing with both pain and stress is his or her use of drugs and alcohol. Drug addicts and alcoholics are generally ill-prepared to deal with the inherent stress related to early recovery.

The stress that is experienced seemingly comes from everywhere. It comes from all aspects of their environment, from their feeling states, interpersonal conflicts and negative cognitions. For example, an unexpected negative encounter with a former spouse may lead to a negative cognition ("I am a bad person"), which may lead to a negative feeling state (guilt or shame). This negative feeling state is very uncomfortable and a newly recovering drug addict or alcoholic may begin to crave drugs or alcohol, knowing that the negative feeling state can be at least temporarily relieved.

Although this example suggests that relapse is rather straight-forward and simple, this is seldom the case. Most early-recovering drug addicts and alcoholics have a great amount of ambivalence concerning their continued use of drugs and alcohol. This ambivalence makes it much more difficult to immediately turn to drug use, but the ambivalence also leaves open the option of returning to drug use to calm the negative emotional state that early recovery usually brings.

Avoiding relapse is critical to successful outcome, but as Gorski (1990) suggests, the difficult aspect of recovery is not staying away from drugs and alcohol, but is learning to be comfortable in sobriety. The following section reviews this topic.

### *Models and Characteristics of Recovery*

Recovery, for the purpose of this research, is operationally defined as living free of addiction to drugs or activities and discernable improvement in level of functioning (Stevens, & Smith, 2001). A closer look at his definition makes

**clear several important concepts concerning recovery from addiction. The first is obvious – to be in recovery from addiction, a drug addict or alcoholic must completely discontinue their drug of choice.**

**The second concept is less obvious, but one that is often observed in individuals. This concept is often termed “substitute addiction.” Substitute addiction occurs when individuals are able to quit their drug of choice, but they substitute another psychoactive substance or become addictively (compulsively) involved in some activity. A fairly common substitute addiction is exercise. In this case, a person may simply decide to exercise for all of the same reasons that he or she used to drink, smoke, gamble, use drugs, or binge eat (Prussin, Harvey & Digeronimo, 1992).**

**A third concept in the definition of recovery is the idea of increased level of functioning. When a person stops using his or her drug of choice, they often feel worse. A common example of this is nicotine addiction. Initially, not using nicotine causes the individual great discomfort. This is primarily due to the physical withdrawal from nicotine. These withdrawal symptoms last anywhere from nine to 28 days. As uncomfortable as these symptoms are, most people who quit smoking can out-last the physical symptoms. Unfortunately, the battle to stay nicotine-free has just begun. The psychological craving for this drug lasts, in many cases, for years. The same is true for other psychoactive drugs. Also, for most alcoholics and other drug addicted individuals, their drug of choice was their primary coping mechanism for dealing with the normal mood fluctuations of life. Add to this mix the fact that most drug addicts and alcoholics had not been**

dealing with their reality in a very effective way while using drugs and alcohol and we find that the recovering persons level of functioning tends to be very low.

For these reasons, many alcoholics who experience this will relapse within the first 90 days of abstinence (Cummings et al., 1980; Gorski, 1990). For those who do not relapse, their level of functioning gradually begins to improve (Gorski).

Usually by the end of their first year of abstinence, a drug addict's or alcoholic's level of functioning is much improved, and this will potentially continue (Gorski, 1990). But, there are those individuals who remain abstinent for a long period of time, and who's social functioning does not improve. This often is termed a "dry drunk" (Kinney, 2000), or "white knuckle sobriety" (Stevens, & Smith, 2001). This uncomfortable state can last indefinitely, but usually culminates in a relapse episode (Gorski, 1990). What causes some individuals to remain abstinent from alcohol and other drugs and to not improve in their social functioning, and others to change so radically in their social functioning that some describe their change as a personality transformation is described in the following section which reviews the relevant literature concerning the characteristics and theories of the process of recovery.

This section is divided into two subsections. The first subsection will discuss briefly four different theories that have been developed to describe the process of recovery and the second subsection will review several empirical studies concerning the characteristics of the process of recovery. Unlike the studies that reviewed characteristics of relapse, this section will consider the

characteristics that are more enduring; that sustain and enhance the recovery process.

### *Theories of Recovery as a Developmental Process*

Recovery from the problematic use of drugs and alcohol often has been described as a developmental process (Brown, 1985; Clemmens, 1997; DiClemente, Prochaska, Fairhurst, Velicer, Velasquez, & Rossi, 1991; Lawson, et al., 2001; Gorski, 1990; Pita, 1992). The process of addiction is too a developmental process, but the process of recovery and the process of addiction are not mirror images (Brown, 1985). For the process of addiction to continue all an individual must do is to continue to drink or use drugs. The process of recovery is much different. Merely not drinking or using drugs is only a first task which must be followed by more complex tasks if the developmental process is to occur. This section will review the literature related to the characteristics of recovery from a developmental perspective.

*Stages of Change Theory.* Recovery from the problematic use of drugs and alcohol is difficult for many individuals. As discussed in the previous section, the newly abstinent drug addict or alcoholic will struggle with many obstacles to their recovery. As difficult as these may be, it is only the beginning of a long process. In general, the longer a person has been abstinent, the more likely she or he will continue to remain abstinent. A general way of looking at this issues is the statistics that look at members of AA. These statistics suggest that relapse is most common in the first 90 days of abstinence. After one year a person has a 70% chance of remaining abstinent. This percentage goes up each year until,

after five years, an individual has a 90% chance of remaining abstinent for another year (Leach & Norris, 1977). Obviously, relapse is much more likely in the first year, but, relapse can and does happen even after long-term sobriety. Also, the amount of time a person is abstinent in and of itself does not suggest that an individual is accomplishing the necessary tasks for the developmental process of recovery to continue.

Several of the theories of the process of recovery include the process of cessation. DiClemente, et al. (1991) describe a Stages of Change theory that primarily focuses on the process of cessation. Obviously, the process of recovery must begin with the process of cessation.

The first stage of this theory is the *Precontemplation Stage*. In this stage drug abusers do not see any problem and feel that everything is under control. Here they may seriously consider quitting, but do not actually try to quit. They are ambivalent, but the seeds of change may be beginning to grow. As the process of addiction continues, this ambivalence allows hints and negative feedback from others to seep into their consciousness. This, begins the *Contemplation Stage*.

During the *Contemplation Stage* they may consider cutting back on their drug use to see if the situation improves. It is a period of identifying and weighing the costs and benefits of change.

The next stage is the *Preparation or Determination Stage*. During this stage they not only think seriously about change, but also start making efforts to cut down or quit. Over the next few months an action period occurs in which



serious efforts to quit are made. An individual may enter treatment, begin attending AA or they may simply quit.

The last stage of the DiClemente, et al. (1991) model is the *Maintenance Stage*. This stage commences when a person has achieved six months of continuous success. The task of this stage is to continue the success that he or she has achieved. Like DiClemente, et al., Gorski (1990) states that the cessation process is also part of the recovery process. Unlike DiClemente, et al., however, Gorski puts much more emphasis on the actual recovery process.

*Gorski's Process of Recovery.* Gorski describes six stages to the recovery process. The first two stages are part of cessation process and the last four detail the process of recovery, after cessation.

The first stage is called the *Transition Stage*. This stage commences as a result of the pain of the addiction becoming more difficult to deny. A common example is when a crisis related to use of psychoactive substances occurs. This crisis initiates a different reality to addict's thinking in how their drug of choice is impacting their life. Denial is still present, but the crisis may initiate the treatment process, and although reluctant, they become willing to at least look at their relationship with their drug of choice.

The second stage is called the *Stabilization Stage*. According to Gorski, this stage usually involves treatment. While in this stage, the primary task is to resolve whatever the presenting crisis is and to develop a realistic post-treatment plan to attend to the myriad of problems that each recovering individual will face.

***Early Recovery*** is the next stage. The primary focus of this stage is staying drug-free and learning to be comfortable while maintaining abstinence. Tasks involved in this stage include understanding and acceptance of addiction, identifying and interrupting addictive thinking feeling and acting, learning non-chemical coping skills, and developing a sobriety-centered value system. This stage often lasts a year or longer. Most recovering people begin to feel comfortable in sobriety somewhere between six months and a year.

The next stage is ***Middle Recovery***. This stage commences when acceptance of addiction is a given. An individual is feeling comfortable in recovery in this stage. The primary focus of this stage is repairing addiction-caused damage and resolving the demoralization crisis of discovering how much is yet to be done, that staying sober is only part of what recovery is. Toward the middle of this stage, it is obvious to others that deep seated changes are taking place. Levin and Pinkerson (1998) describe this as "coming home." Gorski explains this as a reunification of core values, meaning that in the addictive stage, important core values were not demonstrated by behavior, but during this stage a recovering individual's behavior and values will be more congruent. Also, during this stage it is not unusual for difficult decisions to be made regarding career and interpersonal relationships. This stage can last for several years.

The ***Late Recovery*** stage is a stage in which some recovering drug addicts and alcoholics have a very difficult time, while others seem to hardly struggle with this stage. This stage commences when an individual is having difficulty maintaining a balanced lifestyle. The cause of this, is often related to

significant, unresolved issues from one's family of origin. In order for recovery to continue to be a growthful experience, the recovering individual must now recognize that problems he or she are having as an adult (usually, with his or her ability to establish and maintain intimacy) are related to unresolved family of origin issues.

For some recovering individuals, the nonresolution of these issues culminates in relapse. Researchers have observed those in recovery with five to ten years of recovery go back to their drug of choice – this relapse often will culminate in death (Gorski, 1990).

Many recovering individuals seek counseling to assist in resolving these issues. For some it is just a matter of revisiting their childhood and making a deliberate attempt to understand what happened in their childhood and how they have been impacted. Journaling and verbalizing some of their feelings are often tasks that give clarity and initiate the healing process. With this resolution, the final stage of recovery can commence.

The last stage is called the *Maintenance Stage*. This stage allows for the completion of the personality transformation through continuing growth. Gorski (1990), puts a great amount of emphasis on the post-treatment aspect of recovery. According to Gorski, relapse can occur at any stage if the tasks of that stage are not successfully completed.

*Brown's Developmental Model of Recovery*. Like Gorski (1990), Brown (1985) developed a theory of the process of recovery that also puts emphasis on successful task completion. Brown studied 80 recovering alcoholics (40 men and

40 women) all of whom had been involved in Alcoholic Anonymous, attempting to understand recovery in terms of cognitive and psychodynamic developmental process.

Although Brown's Developmental Model of Recovery is similar to those already discussed, her theory relates changes in addictive behavior to broader cognitive and affective changes that occur at each stage of recovery (Wallen, 1993). Brown relies heavily on the cognitive-developmental theory of Piaget. Brown also draws on the work of Rosen (1985). Rosen uses cognitive developmental principles to understand psychological principles (Wallen).

Recovering drug addicts and alcoholics in early recovery (the first 12-18 months) often demonstrate "arrested development." Brown helps us to understand the nature and meaning of this phenomenon. Brown has identified the following four phases: *drinking*, *transition*, *early recovery*, and *maintenance*.

During the *Drinking Phase*, there is a heavy predominance of assimilation over accommodation. This helps to explain why the drug addict or alcoholic is the last to understand that drugs and alcohol are causing her or him great difficulty. This, is normally referred to as denial. For addiction to occur, there must be a level of denial that defies logic. "Maintaining this belief structure involves a massive constriction of incoming information, to the extent that where, the issue of drinking is concerned, the alcoholic's thinking is illogical and disordered" (Wallen, 1993, p. 54). The task in this stage is to dispute the denial, so that the transition stage can commence. Often, this is done in the treatment

**process. It is not often that a drug addict or alcoholic can defeat this denial without assistance.**

**The *Transition Phase* is marked by concrete thinking. During this stage there is a shift of thinking from denial (thinking that one can control one's drinking) to an acceptance of loss of control and that one is an alcoholic or drug addict. During this phase, the newly abstinent alcoholic or drug addict feels an overwhelming need to follow direction, that the answers to remaining abstinent lie within others. Those who have a good support system tend to rely heavily on this system and those who do not have a support system tend to have a great deal of difficulty remaining abstinent during this phase. Crises related to using their drug of choice are common during this phase and the crisis, if resolved successfully, is done so by relying heavily on the instruction and guidance of others.**

**The *Early Recovery* phase "is a more stable continuation of the transitional phase" (Wallen, 1993, p. 58). Thinking tends to remain concrete, but confidence in remaining abstinent increases and a person begins to rely on his or her own experience in making decisions when confronted by new situations concerning his or her drinking or other drug usage. Also, during this phase an individual will experience affect in a way that they have not encountered before. Suppressed feelings from the past may emerge and often an individual will begin to experience depression or anxiety. In essence, a new cognitive organization is developing, but at an early developmental stage. A person during this phase may feel that he or she has regressed. "The individual who appeared to operate at a**

higher cognitive and affective level during their drinking, now appears to have lost these abilities or regressed" (Brown, 1985, p.58). Often, a person will feel that he or she is on an emotional roller coaster. Also, during this phase an individual will think he or she has it all figured out at one moment and the very next moment may feel that he or she does not have a clue as to what he or she should do.

The last phase in Brown's scheme of the process of recovery, is the *Ongoing Recovery Phase*. During this phase, recovery becomes natural and the identity of an alcoholic is fully incorporated. The individual is more flexible and is able to more easily understand and use abstraction. More self-regulation and self-exploration is the norm and reliance on external support will take on a different, more independent meaning.

*Clemmen's Self-modulation Model*. The last theory of the process of recovery that will be discussed is Clemmen's (1997) self modulation model. This model is an attempt to provide a description of an addict's behavior as well as of the meaning of that behavior (Clemmens). This model describes the stages of recovery "as an incremental restoration and development of the addict's social and psychological integration" (Clemmens). He describes three distinct stages: stage 1 – Early Recovery: Development of Self and Self-Boundaries, Stage 2 - Middle Recovery: Relatedness and Differentiation, and Stage 3 – Later Recovery: Expanding Self. Each stage will be discussed briefly.

The struggle in early recovery is focused on learning to "bound out" drugs and alcohol and to become increasingly sensitized to self (Clemmens, 1997). In

other words, this stage is about self and the development of boundaries. The tasks associated with stage are: maintaining abstinence through self-regulation, developing retroflection, and developing sensations into awareness.

The first task, maintaining abstinence through self-regulation is working with the client to help them see that they do have an alcohol or other drug problem and that abstinence is required. Most drug addicts and alcoholics, when they accept their addiction become motivated to attempt to be abstinent. This is usually not initially easy, but through external support and a supportive environment, much of the emotional and physical pain and the cravings that occur, can be dealt with successfully. Detoxification and or treatment may be necessary at this point. Involvement in a 12-step program such as Alcoholics Anonymous or Narcotics Anonymous usually is indicated and helpful also.

The second task of early recovery is to inhibit the desire for the drug by developing retroflection. Retroflecting, for the addict, is pulling an arm back from the drug or drink, or stopping any action toward using drugs or alcohol. It is a counter-movement of inhibition, and may include a consideration ( awareness) of what using drugs would mean. It is a process of being aware in the moment and thinking through the meaning of using the drug, and the inevitable consequences that have occurred before.

The last tasks of *Early Recovery* is developing sensations into awareness. This task is about "developing sensations they have habitually avoided into clear feelings they can experience, articulate, and understand" (Clemmens, 1997, p. 43). The use of their drug of choice was often an attempt to avoid feeling, now

**the recovering person is ready to begin to feel. This initially will be new and painful, but it allows them also to become fully aware of and experience both self and others rather than to react to avoid that experience.**

***In the Middle Stage of Recovery, recovering addicts begin to move beyond the exclusive focus on self-boundary and sobriety and to include others in their field of awareness. The tasks of this stage are steps toward increased awareness and involvement of interrelatedness and include complementarity, boundary flexibility and redefinition, interpersonal competence, and cooperation (Clemmens, 1997).***

**The task of complementarity means that the alcoholic needs to develop a complementary rather than competitive relationship of the world. The task at this stage is for the addict to experience how they are similar to other addicts. This supports them as they clearly identify the process of addiction and recovery, and develop a support system. As example, in adolescence and other transitional periods of life, what are absorbed are role models, examples of what it is to be an adult. In recovery, what are absorbed are possible models of recovery, examples of how to live without alcohol or drugs.**

**The second task is boundary flexibility and redefinition. Addicts are notorious for being very rigid while in the active stage of addiction. It is essential that the newly recovering addict learn to have flexible boundaries, ones that can allow both contact with others and attention to self. If this does not develop, there will be tendency for the addict to go from one pole to the other, from rigid**



overbounded focus on self as distinct from others and environment to an overly permeable, unbounded merger with others and environment.

The third task is interpersonal competency. As a result of living in complementary relationships and learning to expand and flex their boundaries, recovering addicts can achieve a sense of interpersonal competency, a process of fluidly interacting with others. What is fluid is the addict's ability to make contact with others yet maintain a sense of self, a skill that supports an increasing variety of choices and behaviors for him or her in recover. Many recovering addicts tend to experience their choices as dichotomous, either for "me" or for "you." Interpersonal competency is the capacity to negotiate both our self-needs and our ongoing embeddedness in a field of others. This competence is based on subskills that include the ability to support and ground self, to express one's own experience clearly, to receive others' experience accurately, and to negotiate between self and others. Individual, couples, family, and group therapy can be most useful and sometimes essential for recovering addicts to develop the above skills.

The last task of the *Middle Recovery* stage is cooperation. This task is to become more involved in the world around them by becoming involved in service work in AA or NA or becoming involved in community or political activities. This task helps the addict to integrate themselves better in the larger systems of their existence.

The last stage is Stage Three – *Latter Recovery: Expanding Self*. In this stage of recovery, the focus is on the experience of moving beyond immediate

**feelings and reactions to observing self and later observing and experiencing self in relation to all systems. The recovering addict in this stage learns or develops the capacities to observe and reflect upon self and to transcend immediate feelings (while continuing to feel). This is the stage of recovery where the addict develops deeper meanings of existence. The two tasks of this stage are 1) reflection and contemplation and 2) transcendence.**

**Reflection and contemplation is the process of reflecting more fully on the meaning of experiences. This stage is what Wilber (1986) calls the formal reflexive: the process by which addicts can think about their thinking and the world. It is an introspective mode and crucial to the development of a spiritual practice.**

**Transcendence is the ability of the addict to go beyond self and others to connect with all levels of systems. This task is the ability to be both self and going beyond self. This task refers to spirituality as not just an aid for recovery, but as a way connecting with others beyond self.**

***Summary.* The theories of the process of recovery explain the framework in which recovery progresses. In different ways, all four theories assist in understanding the complexity of the recovery process. As the process of addiction progresses, a constriction of the personality occurs (Kinney, 2000). The challenge of recovery is a reintegration of a truer personality that is more expansive. The above theories of the process of recovery help explain the personality transformation that recovery helps to generate.**

The next section has a more narrow focus. This section reviews some of the characteristics of successful recovery.

### *Studies on the Characteristics of Recovery*

The following studies attempt to isolate and highlight important issues related to the recovery process. Key in most of these studies is their description of various elements thought to be essential for successful recovery.

The first study summarizes findings from two longitudinal, prospective studies that were initiated between 1939 and 1944 (Vaillant & Hiller-Sturmhöfel, 1996). Participants of the first study (The College Sample) consisted of 268 Harvard University students who were recruited from the sophomore class between 1939 and 1944. Participants of the second study were 456 males from the inner-city of Boston (The Core City Sample) who were a control group for a sample of juvenile delinquents. They were matched with the juvenile delinquents by age, intelligence, neighborhood crime rate and ethnicity. The participants in the core city sample, predominantly came from lower social classes with a variety of ethnic backgrounds. This group was selected between 1940 and 1944 when the participants were between the ages of 11 and 16.

This article summarizes findings from the studies related to the development, course and outcome of alcoholism from the participants. This review will focus on the factors that Valiant found to determine the outcome of stable abstinence for the participants in these two samples.

Over time, 110 of the 456 Core City sample participants (24 percent) developed alcoholism and 47 of them achieved "stable abstinence" by age 60

(22 percent). Of the college sample, 52 of the 268 participants (19 percent) developed alcoholism and 10 achieved “stable abstinence” by age 70 (19 percent). For both the Core City and College samples, stable abstinence was defined as consuming of alcohol less than once per month for at least the past three years.

Comparing the participants who did achieve stable abstinence from those who did not from both samples, revealed that the only predictive characteristic for stable abstinence was AA attendance. Treatment for these participants was not a factor on who obtained stable abstinence. In other words, many who were treated for their alcoholism, did not obtain abstinence, and many who did not receive treatment, spontaneously remised. For the Core City sample, nearly half, retrospectively, credited willpower as a factor for their success, but prospectively, willpower failed to predict a positive outcome.

Several non-treatment related factors seemed to influence outcome. These factors were, substitute addiction, behavior modification, enhanced hope and self-esteem, and development of a “new” love relationship. Substitute addiction ranged from food, and other psychoactive drugs, to work, dependency on parents or AA. Behavior modification included the threat of loss of employment, health, legal or medical consequences, etc. Enhanced hope and self-esteem included AA participation and/or evangelical religious involvement. Involvement in a new love relationship meant a new spouse or mentor, contrasted with renewal of existing relationships which were less effective.

**De Soto, O'Donnell, Allred, & Lopes (1985) studied psychopathology and symptomatology of alcoholics with varying lengths of abstinence. The Symptom Check-list 90 (SCL-90-R), a self-report instrument with coverage of psychopathology and symptomatology, was utilized. This sample consisted of 312 mixed gender alcoholics. The males had an average of 6.2 years of abstinence and the women an average of 4.9 years.**

**The primary finding of this study was that the recently abstinent alcoholic is highly symptomatic in early recovery and over time these symptoms gradually subside, with those with over ten years of abstinence showing near normal levels of symptoms. This finding supports the concept that recovery is a process. This study did not attempt to discuss the factors that create the change.**

**Sommer (1992) employed a qualitative design to study members of AA with varying lengths of abstinence. Interview data was used to generate characteristics of recovery.**

**Participants of this study had four to seven years of abstinence. Using the questions "What are the most important things they have learned in sobriety and how do they solve problems in their lives today," the following five key themes were generated 1) a change in how they view the world and solve problems, 2) attribution of events to a "higher power," 3) a newly acquired sense of self-efficacy and accomplishment, 4) the development of "faith" and specific sense of what their "higher power" was, and 5) a sense of security and hope, primarily derived from AA.**

**Morgan (1995), qualitatively studied, the lived experience of persons in recovery over the long-term. Participants were all white males who had at least 10 years of sobriety through AA. This research revealed the following three themes: re-visioning of self, re-visioning of life-context, and restructuring of life-stance and lifestyle. Each of these themes will be discussed briefly.**

**Re-visioning of self refers to the ability to see clearly who they had become in their addiction. This vision of the addictive self usually involved the metaphor of being lost in the sea of humanity, of losing their way. But the being lost was not innocent. In this lost state, these participants also shared how they had degraded and dehumanized themselves. In recovery they described being "rescued." With this rescue came the opportunity for ongoing restoration and transformation of self. The re-visioning is about acceptance of the past and the responsibility to continue the process of change. "I am not simply another alcoholic but an alcoholic who was rescued and saved" (Morgan, 1995, p.66).**

**The revisioning of life-context is about the core belief that their life is guided by a "higher power." This makes a profound difference in their life. They have confidence and their belief sustains them through good and bad times. They understand their lives as secured by "providence."**

**Basic to long-term recovery is the ability of the recovering individual to restructure their lifestyle on a concrete and daily basis. This involves daily rituals and practices, sometimes referred to as "tools" that assist in maintaining and nourishing recovery. Example of these tools would be self-affirmations, AA**

attendance, "recovery work" related to working the 12-steps of AA, and recovery work with others.

The studies reviewed up to this point have focused on individuals in recovery and factors that effect their recovery, however, couples also are impacted. The following study focused on the specific recovery issue of how long-term recovery manifests in married couples.

This study explored the histories of six successful long-term couples who married before one or both of the partners developed alcoholism (Smith, 1998). The intent of the study was to discover characteristics of the couple and the individuals that facilitated the process of recovery, and their ability to survive the dysfunction of alcoholism.

Analysis across the six case studies revealed life-long qualities of character among the participants that included tenacity and trustworthiness. As the recovery process developed, so did characteristics of empathy, assertiveness and acceptance of self. Most of the couples were willing to get appropriate levels of help, when needed, throughout the recovery process. All the couples shared that as individual spiritual growth occurred, there was a positive impact on the couple as well.

The models and studies reviewed thus far suggest that the transition from active addiction to recovery requires support. The most available support is that which comes from AA and NA. Although these support programs have been popular for many years, the curative factors are not clear. (Watson, Hancock, Gearhart, Mendez, Malovrh, & Raden, 1997). This study describes the process of

recovery in AA as a process of personal narratives being shared in a specific manner that created the opportunity for growth to occur.

This study suggested that the personal narratives are an integral part of the recovery process because the signs that are used, and the semiotic webs that they form, are similar among people who belong to 12-step groups. The author states that these personal narrative serve as a form of catharsis or release, and the public nature of this release creates a semiotic relationship between speaker (performer) and group (audience). The healing comes from the catharsis and the mutual identification of its participants.

Although some of the research completed on the recovery process has included women, a vast majority has studied men only. The following two studies considered the process of recovery for women. The first one discusses the more specific issue of childhood abuse and the recovery process for women (Miller & Stermac, 2000).

The prevalence of women in treatment for addiction who have experienced traumatic childhood abuse is staggering, with estimates ranging from 15-57 percent as compared to the general population of 4-27 percent (Polusny & Follette, 1995). With this abuse comes lower self-esteem (Miller, Downs, & Testa, 1993) and issues of fear, anxiety, and shame (Browne & Finkelhor, 1986). These issue usually are not attended to in treatment, but will manifest themselves in the recovery process.

The clinical literature fails to document the process of recovery through which adult survivors of chemical addiction and childhood abuse overcome these



**experiences (Herman, 1992). This study is an attempt to address this gap in knowledge by documenting and describing a selection of the recovery tools women employ in healing from addiction and abuse experiences.**

**Using a qualitative approach, the following four themes emerged, 1) reshaping the concept of self, 2) managing emotions, 3) developing a new sense of identity, and 4) forging adaptive attachment styles. Each will be discussed briefly.**

**Reshaping the concept of self is the process of acknowledging and releasing the false fronts, masks or roles they had developed to manage their trauma and substance abuse issues. The other three themes are necessary for this reshaping process to occur.**

**Managing emotions is about the ability to cope with pain, stress, and negative affective states without using chemicals to alter those states or to deaden them. This entailed a four step process for the participants. They needed to identify the emotional experience, find meaning of the emotions, confront the painful emotions, and cultivate positive emotions.**

**Developing a new sense of identity for the participants meant confronting past violations against self, connecting to self and committing to the newly established sense of identity. The act of releasing and mourning past events, behaviors and feelings were an important process for developing a new sense of identity. The grieving of the old self was related to both the victim of abuse and the chemically dependent self.**

**Forging adaptive attachment styles consisted of the three sub themes of breaking the silence, connecting with others, and changing ways of relating to others. Breaking the silence was done by talking about their abusive and addictive past. Learning to connect with others was accomplished by sharing with others who had similar experiences, and changing ways of relating to others meant breaking the cycle of dysfunction by breaking the silence and connecting with others who had similar experiences.**

**The last study on the process of recovery also concerned women and the process of recovery. The purpose of this study was to better understand women's experience in recovery from alcohol (Rankin, 1999). Qualitative methodology also was used for this study. Participants came from mixed gender AA groups, women's AA, and a non AA affiliated group called Women for Sobriety. The three predominant themes that emerged were, the importance of interpersonal processes and relationships for women in recovery, the importance of feelings related to pain, low self-esteem and depression, and spirituality as an important recovery experience. Other less emergent themes were the impact of sexual trauma, family involvement in their recovery, and gender differences of those in recovery.**

**The intent of the present study is to learn from 15 recovering drug addicts and alcoholics what were the processes and themes of their successful recovery. Two studies have been completed that had a similar objective. The first study was completed in 1987 (Russell, 1987). The purpose of the study was to investigate elements or themes that may be involved in successful recovery from**

chemical dependency. The purpose of the second study was to study long-term alcoholics who had at least six years of sobriety/abstinence to ascertain how they understood their success (Kubicek, 1998). A naturalistic, qualitative design utilizing multiple case studies was employed for both studies. The sample consisted of 14 alcoholics for the Russell study and 13 alcoholics, six of who were "spontaneous remitters" in the Kubicek study.

Most of the themes from the Russell (1987) study focused on the outcomes or results of sobriety that the participants claimed. These included such things as improved health, appearance, mental alertness and family relations along with developing positive goals and having a more positive attitude. Participants also learned in their recovery not to attempt to control others and focus more on changing self. Obviously, the factor of appreciating positive benefits from sobriety is important in maintaining change, but this factor is only one of several others. Other factors that emerged in the Russell study that preceded or coexisted with the positive change factor were a developing spiritual belief, use of will power, acceptance of their addiction, and a willingness to go to any length to obtain sobriety.

In contrast, the participants in the Kubicek (1998), study revealed that important processes or themes for them were the use of the help of others, a strong desire to change, acceptance of their addiction and a strong memory of the consequences of their addiction. Only three participants stated that the benefits of a sober life were important in their successful recovery.

Kubicek (1998), compared participants who recovered in different ways. Seven of his 13 participants used AA or NA to support their recovery, and six participants were never treated for their addiction and did not use AA or NA. Although there were differences in the themes of these two groups, the difference did not seem very dramatic. As an example, four of the six spontaneous remitters felt that the utilization of supportive people, having a strong desire to get better, and remembering the negative consequences were important themes. All seven of the AA/NA group felt the utilization of a supportive people were important, only four of seven felt their strong desire to get better was important, and only three of seven felt remembering the negative consequences was important. The biggest difference in these two groups was concerning the theme of acceptance of God or a higher power. Six of seven of the AA/NA group thought this was important whereas only three of six of the spontaneous remitters felt this was a factor.

*Summary.* The models and studies suggest several important conclusions or common findings related to recovery. The first is that recovery generally is seen as a series of tasks that must be accomplished for recovery to continue. Second, the process of recovery is not automatic and does not occur only as a result of abstinence; abstinence is required for recovery, but other tasks also must be accomplished. The third important finding is that there are a myriad of influences on the recovery process and like the relapse process, it is often a combination of these factors that influences the process.

The reviewed literature also suggests that recovery is a process during which profound changes take place. The literature revealed some common themes. The first of these themes is acceptance. Acceptance means acceptance of the addicted past as well as acceptance of the addiction itself. A following theme to acceptance, is a willingness to seek assistance and support from others. A third theme is related to the concept of moving on with life by being more connected with both their environment and important people in that environment. The recovery process also means understanding and dealing with feelings in a more helpful way. A final theme is the existential concept of their place in the world. This often has overtones of a greater understanding of their finiteness and defining and pursuing their spiritual self. It can be seen that if a person accepts their addiction, but is unwilling to seek assistance or help from others, they may not be very happy in recovery and will most likely experience a relapse. Each of the above "tasks" seems to be equated with successful, long-term recovery.

The following succinct summarization captures some of the complexity of the recovery process. The process of recovery involves acceptance of the addicted self; a reaching out for support, direction, and hope; a reconnection of self with others; and initiating a sense of self within a larger context or system.

Another important question is, "Do the above themes and processes apply to those who do not receive professional treatment and who do not use AA or NA for support?" The following section will review the research that addresses this question.

### ***Natural Recovery from Addiction***

**Until recently, the subject of spontaneous remission has received almost no attention in the recovery literature. Vaillant (1983) in his analysis of two prospective, longitudinal studies was one of the first investigators to document this subject. The questions of the prevalence and casual factors are important questions that we are just beginning to answer.**

**This section will review the literature related to the issue of spontaneous remission or natural recovery. These two terms, and others, are used interchangeably. As mentioned in Chapter I, this topic has not been studied to great detail. As evidence to the paucity of literature on this subject, in a review of eight commonly used textbooks for teaching addiction courses, none referenced this topic. Six of eight textbooks reviewed had copyrights dates of 2001 or 2002. And even though this topic has not often been studied, there is evidence that many, and some suggest most, drug addicts and alcoholics obtain abstinence in this manner (Smart, 1975/1976; Goodwin et al., 1971; Sobell et al., 1993; Peele, 1989).**

**This first study, examines the characteristics of middle-class alcoholics and drug addicts who terminate their addictions without the benefit of treatment (Granfield & Cloud, 1996). The participants of this study were 46 alcoholics and drug addicts who were identified through snowball sampling techniques. All participants reported having stable middle-class backgrounds. Thirty of the participants were male, and 16 were female. Data were collected through in-**

depth interviews. The following is a brief discussion of the themes that were revealed through the interview data.

The first theme was the postaddict identity. Unlike most treatment programs and 12-step programs that stress the importance of the alcoholic/addict identity, what emerged from this study was a staunch anti-addict identity. The participants of the Granfield & Cloud (1996) study saw their addiction as something from the past. They did not consider it much in their current thinking and they seldom even talked about it. In fact, two-thirds of the participants refused to identify themselves as presently addicted or as recovering or even as a recovered addict. Their past addiction was not central to their current self-concept.

The second theme was circumventing treatment. All participants made a conscious effort to circumvent treatment. This was primarily because they did not see any consistency between their own world view and the core principles of commonly available treatment programs, namely the 12-step view or disease concept of addiction. Participants typically rejected that they were powerless over their drug of choice; most saw themselves as efficacious and prided themselves on past accomplishments. They also viewed themselves as individualists and strong-willed. These characteristics seemed in conflict with how they perceived treatment and 12-step groups. The participants reported that they disliked the cultural of 12-step programs that they saw as breeding dependency. They saw these groups as cliquish and living in the problem as opposed to getting on with

**their lives. Most women felt their needs as women were not being met in these male dominated groups.**

**The last theme of this study was the element of cessation. The participants were from middle-class backgrounds. As a result, these individuals were rather conventional in most respects and had a stake in conventional life. Drug taking behavior for this group was deviant. Peele (1989) argued that individuals with greater resources in their lives are well equipped to overcome drug problems. Such resources include employment opportunity and credentials, education, job skills, meaningful family attachments, and support mechanisms. The participants of this study provided evidence of such resources. Most reported coming from a stable home environment that valued education, family and economic security, and for the most part held conventional beliefs. They also reported that there were people in their lives to whom they could turn when they decided to quit. These participants had not burned their social support bridges. Also, the participants reported no problem physically leaving their drug using friends and spouses. They possessed the non-drug using social support and resources to do so. This is best exemplified by a female cocaine addicted participant who, when she got pregnant, had no difficulty leaving both her crack cocaine addicted husband and her addiction and returning to the support of her family of origin. These participants were able to rely on natural communities for needed support, abandon their drug using communities, and build new support structures to assist them in their termination efforts by becoming involved in various social groups, returning to school, or developing new interests.**



The second study concerning natural recovery considered the cognitive processes associated with spontaneous recovery from alcoholism (Ludwig, 1985). This study was an attempt to delineate the thought processes rather than external circumstances associated with initiation and maintenance of abstinence.

Participants were 29 spontaneous remitters, most of whom were recruited through a newspaper ad. All participants had at least one year of sobriety. Twenty-seven of the 29 were men. Their average age was 46, most had some college. Their average length of recovery was 6 years.

The following are themes for initiation of recovery. The first is hitting a personal bottom. A crisis related to their alcohol use created the cognition that their alcohol use had to change. For each individual this hitting bottom had a different meaning. Sixteen of the 29 participants listed this as a theme.

Six participants listed physical illness as the reason they initiated recovery. For most of these six, physical illness pertained to a serious threat of death if alcohol use continued.

Three attributed the development of a physical aversion to alcohol and three stated that they were losing control over the direction of their lives. These three described an existential-like crisis that created their desire to initiate recovery. Somewhat related to this was four participants accrediting a spiritual, mystical or transcendental experience as the basis for their recovery.

These participants indicated that there were three major themes for maintaining recovery. The first was no desire to drink. Eleven of the 29 reported this. The desire not to drink left them in a relatively short time after they initiated

recovery. Sixteen reported willpower as to their key to maintaining recovery, and two reported a physical aversion to alcohol.

This study also reported that 14 participants had negative images or thoughts about alcohol, and thirteen participants stated that they initially had a positive thought or image of alcohol, but these thoughts progressively became negative as their train of thought continued. One participant claimed only positive thoughts or images and one participant's thoughts were too ambiguous to be classified.

The purpose of the next study is to provide a preliminary quantitative analysis of research on spontaneous remission (Walters, 2000). This study attempted to answer the following questions, 1) does spontaneous remission from alcohol, tobacco, and other drugs occur, and if so, at what rate, 2) and are self-remitting individuals fundamentally different from people who continue to misuse these substances or remit through traditional treatment?

Through the use of "crude" quantitative analysis, this study confirmed the reality of spontaneous remission. This study confirmed a general prevalence of spontaneous remission range of from 4 percent to 56 percent depending on the length of follow-up and definition used for remission. This study indicated that there were few meaningful differences between self remitting alcohol and illicit drug abusers and persons who either continued using or remitted with treatment, on a number of pre-remission measures.

Reasons for initiating remission of the self remitters included health concerns, changes in values and goals, and concerns about drug related social

**damage. Cited factors for maintaining change included positive social support, relationship changes, willpower, and identity transformation.**

**In the next study, Prugh (1986) reviewed the literature (four studies) that had considered spontaneous remission. Prugh concluded that, in general, SR's quit drinking for exactly the same reason treated alcoholics do. These reasons include, personal illness or accident, a religious or spiritual experience, money problems, family intervention and "extraordinary events" such as personally humiliating incidents, a suicide attempt or other significant crisis. This review also suggested that the method for quitting for SR's was similar to those who sought treatment and the outcome appeared to be similar as well.**

**This section on spontaneous remission will conclude with an excerpt from Vaillant (1983):**

**If treatment as we currently understand it does not seem more effective than natural healing processes, then we need to understand those natural healing processes. We need also to study the special role that health-care professionals play in facilitating those processes. (p. 283)**

***Summary.* Although there is very limited research in this area, it seems that those who spontaneously remit (SR's) are motivated to do so for very similar reasons as those who seek professional treatment. They recognize the need to change their life radically and they have a clear understanding that their relationship with their drug of choice was causing them enormous problems. Beyond that, there does seem to be some fundamental differences between those who recover by traditional means and those who spontaneously remit.**

From the research conducted, it seems that those who quit without traditional assistance have a greater sense of individuality and belief in themselves (Granfield & Cloud, 1996). Although they may admit they were a drug addict or an alcoholic, they do not see this as important in maintaining change. They clearly see their change as something important and needed, and that the past has little or no connection with the present. Support is needed and sought for by the SR's, but the support seems to be limited to the transition from addict to nonaddict. Existential issues do not seem to be important to SR's.

Although there are similarities between those who seek treatment and more traditional means to achieve recovery, there is also a great amount of contrast. More study of the SR's is obviously needed.

It is obvious that spontaneous remission does occur and maybe at a rather high rate than those who are referred for treatment. Understanding the processes and themes of successful recovery for spontaneous remitters, and incorporating that with knowledge of recovery for those who are professionally treated or use AA or NA to support their recovery will greatly assist all who suffer from addictive problems.

#### *Chapter Summary and Overview of Present Study*

This chapter reviewed the literature as it related to causes, characteristics and models of relapse, the models and process of recovery, and spontaneous remission. This section will briefly summarize these topics and identify gaps that exist in the literature.

The major causes of relapse were lack of participation in aftercare, AA or NA (Fleming and Lewis, 1987; Mclatchie, & Lomp, 1988; Knouse, & Schneider, 1987; Aharon, 2000), responding to cravings that are caused by exposure to environmental cues (Cooney et al., 1987; Rohsenow et al., 1994), negative mood and stressful events (Stowig, 2000; Svanum & McAdoo, 1989; Schonfeld, et al., 1988), and lack of self-efficacy (Cantrell et al., 1993; Burling et al., 1989; Allsop, et al., Phillips, 2000; Bradley et al., 1992). The models of relapse reviewed maintained that relapse is caused by situations, response to these situations (Annis, 1986), negative feeling states (Hatsukami et al., 1981; Pickins et al., 1985), and an inadequate response to the stress caused by change from an addictive state to a recovery state (Gorski, 1990).

The common findings identified in the review of the recovery literature issue highlighted the importance of support, specifically in early recovery (Kubicek, 1998), AA or NA attendance (Fleming and Lewis, 1987; Mclatchie, & Lomp, 1988; Knouse, & Schneider, 1987; Aharon, 2000; Vaillant & Hiller-Sturmhöfel, 1996), and self-efficacy (Annis & Davis, 1991; Coelho, 1984; DiClemente, 1981; Marlatt & Gordon, 1985; Sommer, 1992; Allsop et al., 2000). The recovery literature also identified themes in recovery that are suggestive of success (Brown, 1985; Clemmens, 1997; DiClemente et al., 1991; Lawson et al., 2001; Gorski, 1990; Pita, 1992). This is one of the research questions of the current study. In long-term recovery ambivalence no longer plays a significant role as it did in early recovery. Themes that are suggestive of successful recovery include, the instillation of hope (Vaillant & Hiller-Sturmhöfel, 1996;

**Morgan, 1995; Brown, 1985; Clemmens,1997; Kubicek,1998, Sommer, 1992) an increase in self-esteem (Vaillant & Hiller-Sturmhöfel, 1996; Gorski, 1990; Brown, 1985; Kubicek, 1998; Russell, 1987) self-acceptance (Clemmens,1997; Gorski, 1990; Sommer, 1992; Morgan 1995; Smith, 1998; Miller & Stermac, 2000) and self-efficacy (Annis & Davis, 1991; Coelho, 1984; DiClemente, 1981; Marlatt & Gordon, 1985; Sommer, 1992; Allsop et al.,2000). Additional important characteristics include the ability to reach out and to connect with others (Miller & Stermac, 2000; Rankin, 1999). Perhaps the most critical finding to come from this literature review in regard to long-term recovery, is the change in world view that allows for a sense of awe, incorporation of the concept of a higher power, and the desire to understand and accept responsibility and finiteness (Clemmens, 1997, Gorski, 1990; Brown, 1985; Kubicek,1998; Sommer, 1992; Miller & Stermac, 2000). This last theme ranged from having “God lead me,” to a more existential wonder of the immensity and finality of life.**

**Although the literature on spontaneous recovery is limited, it does suggest that this is an important topic to understand that will assist greatly in understanding the complexity of recovery. From this literature it is obvious that a large percentage of drug addicts and alcoholics achieve recovery this way and that there may be some important differences in how spontaneous remitters maintain recovery as compared to the more traditional ways associated with AA and NA (Vaillant, 1983; Granfield & Cloud, 1996; Walter, 2000; Prugh, 1986).**

**The literature indicates that there are several areas in which more research is needed. The first area relates to the issue of spontaneous recovery.**

It is obvious as to why this population has not been studied. This population is much more difficult to locate. Most studies on recovery have been done with individuals that have received treatment. This population is accessed through treatment facilities. Studying those who participate in AA and NA is also easy to locate. Most AA and NA meetings are "open," meaning anyone can attend, their locations are posted on the web, in newspapers and obtained via a listed telephone number, and they are numerous. Thus, this population is also easy to access and study. To locate spontaneous remitters takes a more effort, patience, and tenacity.

Another gap is related to socioeconomic status. Very few studies have focused on populations other than the easily accessed middle class. Those who reside in the urban core and often do not access treatment have been neglected in recovery research.

We need to understand the processes and themes of successful recovery for those who reside in the urban core and have limited access to treatment resources as well as those who spontaneously remit. Most participants of the current study reside in the urban core, two-thirds either spontaneously remitted or did not use AA or NA to support their recovery after the first year, and nearly half did not consider themselves part of the middle class when they were treated or when they spontaneously remitted.

The current study uses a qualitative approach to understand the process of recovery for three different groups of participants. Semi-structured interviews were employed to learn what the themes and processes of recovery were for

**these groups, and inductive analysis was used to identify similarities and differences in processes and themes among the groups.**



## **CHAPTER III**

### **METHODOLOGY**

#### *Introduction*

**Understanding why it is that one person can have many relapse indicators and still thrive in recovery, while another who has multiple layers of support and opportunity for recovery, succumbs is an important question to consider.**

**Explanations might best be arrived at by understanding the rich context in which the participants exist. For this purpose, qualitative methodology was used.**

**Creswell (1994) described qualitative studies “as an inquiry process of understanding a social or human problem based on building a complex, holistic picture, formed with words, reporting detailed views of informants” (p.2).**

**This study, using in-depth interviewing in the qualitative tradition considered the following two questions:**

- 1) What are the processes and themes of successful recovery from chronic use of psychoactive substances?**
- 2) What are the differences in these processes and themes for the following three groups:**

- those who were treated professionally for their addiction and use Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) to support their recovery**
- those who were treated professionally but did not use AA or NA to support their recovery**

- those who were not treated professionally and who did not use AA or NA to support their recovery.

It seems clear that a “naturalistic” or “qualitative” approach would be the most apt method to learn from “experts,” that is, the participants, as to what made them successful in their recovery. This is not a novel idea. Gergen (1994) has made clear that the research participants hold the key to their private knowledge, and that their “self-narratives” are what is important. It is what they, in their subjective world, understand. Understanding the subjective meaning of another can best be understood through naturalistic inquiry.

The qualitative approach also suggests that the researcher begins the work of understanding the subjective reality of the participants without preconceived ideas as to what to expect, that is, it is a “discovery” approach. The role of the researcher is to use an inductive method by gathering narratives (data) and allowing the data to lead the researcher to the subjective truth of the participant, then discovering patterns of truth among participants. It is possible, then, that the emerging patterns will possibly lead to theory. This is not to say that all prior knowledge is erased from the researcher’s consciousness. This prior knowledge is used not to inform the study, but to compare the emergent patterns with already existing findings (Gergen, 1994).

#### *The Role of the Researcher and Background*

The researcher is the primary instrument in collection of the data. As such, for the present study, it is important that the researcher be competent in

**the interview process, understand addiction and the recovery process, and also understand his own biases.**

**This researcher has worked in the field of alcoholism for over thirteen years. He has been a primary group counselor in three distinctly different settings and has worked as both an addiction prevention and education specialist. He also has extensive experience teaching addiction theory and practice on both the graduate and undergraduate level and also routinely teaches interviewing and counseling skills to undergraduates.**

**The researcher also has attended numerous Alcoholics and Narcotics Anonymous meetings for both personal and professional reasons. The researcher was treated for alcoholism eighteen years ago and has remained abstinent from psychoactive drugs for over fifteen years initially with the assistance of both AA and NA**

**An important issue in the phenomenological approach, in the words of Patton (1990), is that of "epoche." This term refers to the need to acknowledge the preconceived biases that the researcher brings to the study. By "bracketing" this understanding, there is less of a tendency for this bias to influence the outcome of the study. The biases that are here, will be bracketed by this researcher as follows:**

- 1. Although there exist unique individual characteristics that assist in the successful recovery process, there are also relatively common themes and processes to successful recovery from addiction.**

2. **An important characteristic of successful recovery from addiction is the ability of the individual to become interdependent on others and to move from a largely “I” orientation toward an “other” orientation. This orientation includes a developing notion of spirituality that takes the form of “there exists a power greater than myself.”**
3. **Motivation to recover overcomes circumstances that may hinder recovery.**

### ***Participant Selection***

**Qualitative inquiry typically focuses in depth on relatively small samples selected purposefully (Patton, 1990). Participants were selected using a network or “snowball” selection method (LeCompte & Preissle, 1993). The researcher was familiar with several potential participants through professional contacts. Through these individuals, other potential participants were referred. Participants were referred from the following three distinct nodes: 1) university counseling students, 2) an urban substance abuse treatment center, and 2) a military substance abuse treatment center. Participants being referred from these distinct nodes greatly contributed to a heterogeneous group of participants. Appendix A is an example of the solicitation letter that was used. Potential participants were asked to respond to the researcher’s e-mail address or listed phone number. Potential participants were given a copy of the informed consent form (Appendix B). To ensure clarification, this form was explained in detail to the each potential participant. Each potential participant also completed a brief screening sheet (Appendix C). Two primary inclusion criteria were used. First, “Did they meet the**

**criteria for substance dependence as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV) (APA,1994)?” Second, “Did they have at least five years of continuous recovery?”**

**Participants were informed that the primary purpose of the interview was to gain an understanding as to why they had been successful in remaining abstinent from psychoactive substances or compulsive behaviors and to what they attributed their success. Participants were assured that every measure would be taken to protect their confidentiality and that aliases would be used in explication of the results. They also were informed that the preferred method of recording their information was audio recording, but that they first would have to agree to be recorded in this manner.**

**The 17 participants were selected and grouped based on one of the following three criteria: 1) participants who had been professionally treated for their chemical dependency and had used AA and/or NA to support their recovery (this group was called the AA group), 2) participants who have had professional treatment but who did not use AA or NA after the first year of recovery (this group was called the TX group), 3) participants who had not had any professional treatment for their chemical dependency and who did not participate in AA or NA (this group was called the SR (spontaneous remitters) group). Five participants were selected for the AA and TX groups and seven participants were selected for the SR group. A secondary purpose of this study was to learn if there was a difference in the process and themes of recovery for these three distinct groups.**

Table 1 describes the participants in terms of group membership, gender, drug of choice and length of sobriety:

**Table 1**  
**Participant Characteristics**

<b>Participant #</b>	<b>Group</b>	<b>Gender</b>	<b>Drug of choice</b>	<b>Years of Sobriety</b>
1	AA	Male	Alcohol	13
2	AA	Female	Alcohol	13
3	AA	Female	Heroin	5
4	AA	Female	Alcohol/Marijuana	14
5	AA	Female	Alcohol	15
6	TX	Female	Heroin	9
7	TX	Female	Crack Cocaine	5
8	TX	Male	Alcohol	10
9	TX	Male	Crack Cocaine	10
10	TX	Male	IV Cocaine	15
11	SR	Female	Marijuana/alcohol	12
12	SR	Male	Alcohol	16
13	SR	Female	Methamphetamine	7
14	SR	Male	Alcohol	11
15	SR	Male	Marijuana	6
16	SR	Male	Alcohol	19
17	SR	Female	Heroin	6

As indicated in Table 1, nine females and 8 males participated in the study. Participants were also fairly evenly split concerning their drug of choice. Seven participants stated their primary drug of choice was alcohol. Eight participants stated their drug of choice was a drug other than alcohol. Of the eight, three reported heroin as their drug of choice, three claimed crack or IV cocaine as their drug of choice, one stated that methamphetamine was their drug of choice, and one stated their drug of choice was marijuana. Two participants claimed their drug of choice was alcohol combined with marijuana. For all groups combined, the average length of sobriety was 10.9 years. For the AA group, the average length of sobriety was 12 years, for the TX group it was 9.8 years and for the SR group, the average length of sobriety was 11 years. All but one participant resided in an urban environment during their drug addiction and early recovery. Eight of the seventeen stated that prior to their addiction they could be described as economically poor. Six of the eight received some kind of welfare assistance, and three of the eight had not been employed in the job market since high school. All were currently employed.

Application for research involving human participants was made to the Old Dominion University Human Subjects Review Board on September 4, 2001. This review board considered the application, and with minor changes to the application, approved this research on September 20, 2001.

#### *Interview Instrument*

Based on the research questions and research design, questions for the semi-structured interview were developed. The development of these questions

was a process that started out with three general questions in an unstructured format. After rethinking the design with a dissertation committee member and a more exhaustive review of the literature, a modification of the design was made. That modification included reworking the research questions. The three general questions were then incorporated into the categories in which the questions for the semi-structured format were developed. The questions and groupings were modified several times before the final questions were ready to be used in a pilot interview. Based on the pilot interview and conferral with two recovering individuals, two questions were added and one question was deleted.

The next section briefly describes the interview instrument. The first section is the Addiction Phase. There are two questions that were designed to understand the nature of the addiction from the view of the participant.

#### **Addiction Phase**

1. Describe characteristics that were indicative of addiction prior to treatment or recovery.
2. What kind of prior attempts at abstinence did you have?

The next section was designed to better understand the motivations and events of the *Initiation Phase*.

#### **Treatment Phase/Epiphany**

3. Please describe the event or events that created an opportunity for your treatment or recovery.
4. How convinced were you, while in treatment, that you were addicted to your drug of choice?
5. What were the specific event or events that significantly impacted your desire to recover?
6. Many recovering individuals speak of "hitting a bottom." What meaning does this have for you?



The questions in the early recovery phase were designed to understand how they ultimately prevented relapse and moved into recovery.

#### **Early Recovery Phase**

7. Please describe your first few months of recovery.
8. Many recovering individuals speak of a "pink cloud" period in their early recovery, how did you experience this?
9. What were cravings like for you?
10. In what ways do you currently reflect on your early days of recovery?
11. What significant events occurred in the first year of recovery that were difficult for you?
12. What social support did you have in the first year of recovery?
13. At what point in your recovery did you begin to feel good about not using your drug of choice?

Based on the literature review, the relapse phase questions were added.

It was expected that most participants had relapsed and understanding the relapse was important for this study.

#### **Relapse Phase**

14. What were your relapse episodes like?
15. What do you feel triggered this/these episodes?
16. What did you do in response to these relapses?

The last section of the interview instrument was about understanding how the participants were able to recover when so many others do not. These questions were vital in being able to answer the research questions.

#### **Recovery Phase**

17. How would you explain your recovery when others you know have not been successful?
18. Please compare your sense of self while you were using your drug of choice as compared to how you see yourself now.
19. As you reflect on your recovery, what specific factors made your recovery possible?
20. What else can you tell me to help me understand your recovery process?

Each participant was asked the 20 the open-ended questions in a semi-structured format. Each interview took approximately two hours. For each interview, several additional probes were anticipated to elicit more information or to follow-up on a potentially revealing response. Field notes were taken concerning non-verbal behavior, issues relating to how the interview was conducted and other pertinent data from the interview.

Interviews were conducted at a location chosen by both the participant and the researcher. After the analysis, participants were sent a copy of the transcript and a copy of the themes that emerged. The participants were given an opportunity to respond by phone or by interview to the noted themes. Also, at the end of the interview the subjects were invited to discuss their reaction to the interview. Thus participants were included in all aspects of the study.

### *Data Analysis*

After each interview was transcribed from the tape-recorded interviews, the transcripts were analyzed using constant comparative analysis. Constant comparative analysis involves looking at the numerous divided units of the interview and sorting out categories from those units (Glaser & Strauss, 1967). Responses first were organized by question. Topics and categories were identified for each question. The topics and categories then were compared across groups. Once that was accomplished emerging patterns were identified. Quotations were used to verify findings. Figure 1 illustrates this data analysis. Topics were extracted from verbatim responses to the questions.

Figure 1

**Qualitative Data Reduction**

As Figure 1 illustrates topics for each question were then collapsed into categories – this was the first level of analysis. Categories became the basis for developing themes, and the themes were the basis of the process (model).

***Trustworthiness***

Methods for enhancing the reliability of the results were done by the following three methods: First, two experts in the addiction field and one expert with specialization in qualitative methods and analysis were consulted in the question development phase. This was in addition to consulting with other non-participants who were in recovery. Second, two additional researchers with expertise in qualitative data analysis or addictions assisted in the selection of the topics, categories and patterns. This was done in the following manner. The investigator selected all of the topics with verification done independently by one other researcher. The first level of analysis, selection of the categories, was done independently by the investigator and one other researcher for four participants each. After this was done independently, a comparison of the independently selected categories was completed. Differences were discussed and a final

**selection of categories was negotiated. Working together, the negotiated categories were then applied to three more participants. Selection of categories was completed for the final four participants by each researcher with a 97% agreement rate. A third researcher was asked to match topics to categories with an additional option of "other" for any topic that did not match a category. This was done for four participants. The other category was used once for a 98% agreement rate. A similar matching process was used for verification of selected categories to themes. Third, member checking and participant review was utilized in verification of the transcripts and initial analysis. Participants were given a copy of the transcripts and asked to make corrections. Two minor corrections were made. Participants were given a copy of the analysis and asked to comment. Five participants were randomly selected and asked via telephone for comment on the analysis. All participants indicated that the analysis fit how recovery occurred for them. Other methods for ensuring trustworthiness included, using mechanically recorded data and absolute verification of transcripts, using verbatim responses and direct quotes and triangulation across theories of recovery.**

## **CHAPTER IV**

### **FINDINGS**

#### *Introduction*

Chapter IV reports the findings of the study and is divided into two sections based on the two research questions. The first section reports findings related to the first research question, which was, "What are the processes and themes of successful recovery from the chronic use of psychoactive substances?" The second section reports the findings related to the second research question, which was, "What are the differences in the processes and themes for the following three groups:

- for those who were professionally treated for their addiction and use Alcoholics anonymous (AA) or Narcotics anonymous (NA) to support their recovery
- for those who were professionally treated but did not use AA or NA to support their recovery
- for those who were not professionally treated and who did not use AA or NA to support their recovery?"

#### *Process and Themes of Successful Recovery*

As a result of interviewing the 17 participants, the following Multimodal Process of Recovery (MPR) was identified. The MPR emerged from the four phases and eleven themes listed in Table 2. This process of recovery is so named due to the three different modes of recovery from which this model emerged.

Table 2

## Phases, Themes and Number of Participants Experiencing Them

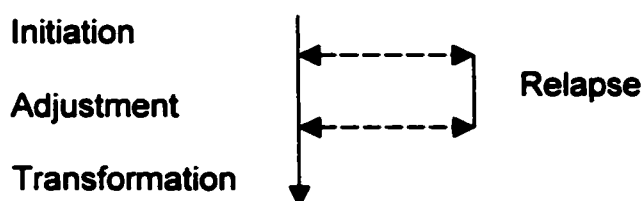
Phase	Theme	Number of Participants
Initiation	Acting on the Need for Change	17
	Internalizing a Desire for Change	17
Adjustment	Learning to Manage Stress and Change	14
	Learning to Live a Sober Life	16
Relapse	Determining the Causes of Relapse	8
	Responding to the Relapse	8
Transformation	Facilitating Change through Spirituality	10
	Facilitating Change through Community Support	12
	Facilitating Change through Family Support	8
	Facilitating Change from Within	15
	Facilitating Change through External Supports	9

The MPR includes the following phases: *Initiation, Adjustment, Relapse and Transformation phase*. The *Initiation, Adjustment, and Transformation phases* were universal for all 17 participants. Although the *Relapse Phase* was not universal for all of the participants, 8 out of 17 participants did experience a relapse during or after the *Initiation Phase* had begun. The *Relapse Phase* is included because, as discussed in chapter two of this study, relapse is such a common phenomena in the recovery process. An additional argument for the inclusion of the *Relapse Phase* in the MPR is that for those who did relapse, the

two emergent themes were universal. The MPR was based on the following eleven themes which emerged from the 56 categories that were identified in the analysis of the participant's responses to the 20 interview questions. Figure 2 illustrates the MPR.

Figure 2

The Multimodal Process of recovery (MPR)



As Figure 2 shows, the *Relapse Phase* is an integral part of the MPR.

This section of the chapter is arranged by phase and related themes. Each theme will be described briefly. The supporting categories with direct quotations are included.

*Initiation Phase*

Although most individuals who experience addiction cognitively know that their addiction is impacting their lives, the important defense mechanisms of denial, minimization, and rationalization deter the cognition. For recovery to commence, there must be a period of clarity in which the addict "Acts on the Need for Change." After taking this initial action, such as seeking treatment or quitting the drug in some other manner, the crisis, that is often the catalyst for change, passes. To sustain the change, post-crisis, the addict must "Internalize a

Desire for Change.” “Acting on the Need to Change,” and “Internalizing a Desire for Change” are the two themes that comprise the *Initiation Phase* of recovery.

***Theme 1: Acting on the Need for Change.*** This theme is defined as taking action on the cognition that a significant problem with a psychoactive substance is occurring. Although this theme may seem obvious it is none-the-less a deliberate action that is prerequisite for the recovery process. Knowing that there is a problem and taking action are two very different behaviors with the later being the first action step in the process of change. All but one of the participants of the current study had previous attempts (nine of which could be described as honest and thoughtful attempts). Only four of the 17 participants were not convinced, while in treatment, or after they had stopped their drug of choice that they were addicted to their drug of choice. Most had previously considered discontinuing their use of the problematic substance, but had not taken any action. The theme of “Acting on the Need for Change” goes much further than simple recognition; this is a deliberate and intentional action.

This theme emerged from the categories that were named in response to the second and third questions of the interview. These questions were, “What kind of prior attempts at abstinence did you have,” and “Please describe the event or events that created an opportunity for your treatment or recovery.” Table 3 shows the categories and percentage of occurrences for question three:



Table 3

**Categories for the Question "Please Describe the Event or Events that Created an Opportunity For your Recovery?"**

<b>Category</b>	<b>Percentage of responses</b>
<b>Fear of negative consequences</b>	<b>66%</b>
<b>Self-motivation to change</b>	<b>21%</b>
<b>Divine intervention</b>	<b>8%</b>
<b>A desire to belong</b>	<b>2%</b>
<b>Formal intervention</b>	<b>2%</b>

Thus, it can be seen that "Fear of Negative Consequences" was, by three times, the greatest motivator for change. The following quotation in response to question three was characteristic of "Acting on the need for change:"

**I was real frightened, I thought I was going to die. I was addicted for over 20 years and I was diagnosed in 1988 as HIV-positive. I really thought I was going to die. I was really afraid and I had gotten out of jail and went back on the corner to hustle and sell my body. This was in New York City and someone almost beat me to death, they actually thought they had beat me to death and they left me out there. I came through that and I was really afraid, and I knew I had to make a change then or I was going to die.**

For all three (AA, TX, and SR) groups, acting on the need for change was important. It is as if the last incarceration or personal crisis was enough, and the result was a deliberate and meaningful effort to prevent another. Each of the 17 participants could identify the event or events that precipitated the action. This is consistent with the previous studies on spontaneous remission (Prugh, 1986; Walters, 2000; Ludwig, 1985; Granfield & Cloud, 1996) which suggest that those

who spontaneously remit are motivated to do so for very similar reasons as those who seek professional treatment. These reasons include a significant loss or humiliation. As Table 4 shows there was some variation as to how this occurred based on group membership (AA, TX , or SR).

**Table 4**

**Variation by Group on Question "Please Describe the Event or Events that Created an Opportunity for your Recovery?"**

Category	Group Percentage		
	AA	TX	SR
Fear of Negative Consequences	58	56	80
Self-Motivation to Change	25	19	21
Divine/Spiritual Forces	0	25	0
Belonging	8	0	0
Intervention	8	0	0

As Table 4 indicates, the category of "Fear of negative consequences" was the predominant category for all three groupings, but was particularly so for the SR group with this category comprising 80% of the responses from this group. Although predominant in the other two groupings also, the percentage was much lower, at 56%, for TX group and 58% for the AA group. The category, "divine intervention" emerged from two of the 17 participants, both of whom were in the TX group.

**Acting on the need to change through accepting that they had a problem was the first important step that was shared by all of the participants in this study. As one SR participant stated "I was definitely convinced that alcohol was nothing but poison - for me I was completely convinced." Only four out of the 17 participants were not convinced while in treatment that they were addicted to their drug of choice. The drug of choice of all four who were not convinced was alcohol and three of the four were in the AA group. All seven SR's were convinced that their drug of choice was a problem. This follows the definition of spontaneous remission, and obviously, if they felt they did not have a problem, they would not have been motivated to quit. A quote from one of the AA participants who was not convinced follows:**

**While in treatment, I believe I was still in a lot of denial. I still focused a lot on the emotional issues and relationship problems. Shortly after I came out of treatment I had a drug dream and it really brought home the intensity of the craving, an incredible craving, more than I had ever experienced before. Then I knew, there was no doubt. I was going to an AA meeting every day but there was probably still doubt even up to the end of the first year, so it took a while for me to be convinced.**

**This first theme, "Acting on the Need for Change," for most participants, was related to an external cue of some sort that the participant was able to translate into a decision to change such as "being sick and tired of being sick and tired" or of being told of some sort of humiliating behavior that had occurred. Theme two follows in a progression and is connected directly with the question that individuals often ask, "What does life mean for me if my drug of choice is no longer an option?"**

***Theme Two: Internalizing a Desire for Change.*** The external “event” that motivated their “Acting on the Need for Change” must now be accompanied with an internal motivation for change that is more lasting. Once the addicted individual has decided that the use of their drug of choice is a problem and they stop or seek treatment, they next must sustain their need for change by creating an internal desire for change. Question 5 of the interview asked the participants, “What was the event or events that significantly impacted your desire to recover (change)?” In a word, the answer to this question was “reality.” For most of the participants, after a short period of abstinence that had been based on their need for change, the reality of their life was starkly in front of them and their defense mechanisms of denial, minimization, and rationalization that had served them so well in their addiction just would not work anymore. Their new sense of reality was too big for these defense mechanisms. And in that reality, the need to change became a desire as illustrated by the following quotation:

**It was the bankruptcy of the spirit, and the bankruptcy of my emotional state. I was miserable, I was depressed, I was anxious and my personal life was in shambles, from my career to my financial situation, to my live-in enabler. But I saw hope in the meetings and that’s what AA offered, that I could recover, and I thought, if all of this crap will go away, if I could do actually what it took to make it go away, I will.**

**As the quotation indicates, this participant now had a desire to recover.**

**This quotation is representative of most of the participants in that there were both internal and external processes at work. Again, this theme emerged across the three groups in a rather similar way. Specifically, theme two was based on the following two questions. Question five asked, “What were the specific event or events that significantly impacted your desire to recover?” and question six**

that asked, "Many recovering individuals speak of 'hitting a bottom'; what meaning does that have for you?" Table 5 shows the categories and percentages for question five.

**Table 5**

**Categories for Question "What were the Specific Event or Events that Significantly Impacted Your Desire to recover?"**

<b>Category</b>	<b>Percentage of responses</b>
<b>External awareness or pressure</b>	<b>54%</b>
<b>Internal awareness or discomfort</b>	<b>38%</b>
<b>Sense of hope</b>	<b>8%</b>

As Table 5 shows, both external and internal factors were evident, but as the following quotations show, the meaning of these were different for this theme in that there was recognition that the change was to not just tied to an event, but that the change was much more systemic. For this question, the responses by category between groups were similar with the following exception. In the AA group, the category of sense of hope emerged from two different participants.

An example of the category of external awareness of pressure is the following quotation: "Because I wanted to continue to fly (an aircraft) and I was worried about employment opportunities." An example of internal awareness of discomfort is the following: "I just had enough. I was sick and tired. I had been locked up so many different times and had lost so much I was a millionaire and I lost it. I lost the business. It was time to just stop. I looked in the mirror."

Question six asked about what meaning the term “hitting bottom” had for them. All but one participant stated that it had meaning and that participant was in the SR group. Of the remaining 16 participants, thirteen said they hit the bottom, with the other three stating they saw the bottom. The following is a quotation from one of the TX group participants who “saw” the bottom: “No I do not think I did hit a bottom, but I saw it coming. I think I had that much sense in me to see it coming rapidly. I saw the train coming and I was able to step out of the way just in time because I think I could have gotten a lot worse.”

A more typical quotation came from a member of the TX group:

**My bottom was when it stopped being fun. I had been betrayed by the closest of friends, and I had betrayed. There is a line in a song that goes something like “I have been down so long that down is starting to feel like up,” or something like that. I definitely feel I hit a bottom, and it was bad enough. Towards the end, I would drive into areas that were very dangerous, by myself, to get my drugs. I lived in a house with no electricity and water – I was disgusted with myself and every aspect of my life.**

The previous quotations suggest that after the decision is made to stop using their drug of choice (Theme One), the newly abstinent person is faced with enormous challenges that create a large amount of stress. As was stated in Chapter II of this study, stress is the natural enemy for people in early recovery (George, 1990; Lewis et al., 2002). Theme 3 addresses this important and difficult issue.

### ***The Adjustment Phase***

Once a person has decided to initiate the change process and has made some progress toward making this change, the next phase of recovery begins. This phase is characterized by managing stress and learning how to live

comfortably without his or her drug of choice. The *Adjustment Phase* comprises the next two themes. Theme three is “Learning to Manage Stress and Change” and theme four is “Learning to Live a Sober Life.”

*Theme Three: Learning to Manage Stress and Change.* For most individuals, change of any kind is stressful. For the participants of this study and most recovering people, the stress associated with the abrupt and radical change required of recovery is a difficult adjustment. A great amount of learning is required. Often, the learning techniques required to deal effectively with the stress of early recovery are a function of treatment programs. As in the case of this study, not all individuals who initiate this change have had an opportunity for treatment or choose to go to treatment. Also, many who do participate in a treatment program, because of depression, inability to concentrate properly or other physiological or psychological issues, do not comprehend the techniques and stress management strategies that are being taught. The participants of this study learned to manage this stressful change in four ways: 1) by being patient and understanding that the positive effects of recovery would happen slowly and, over time, 2) by staying focused on and motivated toward their recovery, 3) by maintaining hope that it would get better, and 4) by leaning heavily on social support. For these individuals this often meant doing anything but using drugs to manage their stress. For example these participants leaned heavily on both their own determination and on the support of others. The support of others took various forms, including church and church-related activities like prayer,

recovering and non-using friends, counselors, mentors or sponsors, and family members.

Theme three, "Learning to Manage Stress and Change" emerged from the categories associated from question seven, "Please describe your first few months of recovery," question nine, "What were cravings like for you," and question twelve, "What social support did you have in the first year of recovery?" This theme manifested similarly across the three study groups. The only exception to this was that NA or AA was not used for support by the SR group and was used by only one member (initially) of the TX group. The TX group cited family as key for their support (four out of the five participants). The SR group used all forms of support except, of course, AA or NA

In response to question seven, two of the five SR's indicated that the first few months of recovery were not a problem and one of the AA participants indicated that they did not experience very much difficulty during this time frame. The other fourteen participants indicated that this period of time was indeed very stressful. The following quote was fairly typical of most of the participants who felt this was a stressful and challenging period:

**It was tough...I was the only one that was different now. I didn't know how to function having different thought patterns... It was real experimental trying to figure out how to accomplish the things I needed to accomplish yet do it in a way that was OK to me regardless of what my boss thought. I did a lot of deep breathing...My home life that was really touchy too...It was like walking on eggshells, I didn't know how to behave around my wife and kids sober... So there was a lot of just sitting back and just not going to say anything because I'm afraid I will say the wrong thing or it is going to come out the wrong way...I really had to think before I did anything whether it was at work or at home. I was scared to death to screw up my sobriety and to screw up the relationship I was trying to develop with my wife and kids and that was the scary part.**



Question nine asked the participants how they experienced cravings. Only four participants stated that they did not experience cravings, and three of these four were in the SR group. Three of the four who did not experience cravings were addicted to alcohol. The one non-alcoholic who did not experience cravings was addicted to marijuana. This person had tapered off gradually over a period of a couple of years. Many spoke of their cravings as being very strong and stressful. One alcoholic participant spoke of her cravings this way:

I experienced very intense cravings. One happened when I was in a 7-11. I was going to have to get the beer, and I didn't even drink beer, I don't think I ever bought a beer in a 7-11. It was really intense and very scary. I think I had been sober about 4-5 months. Something similar happened about three or four months later. I was driving down a street that I had not been down in my recovery, and all of a sudden I felt like I had to get a bottle of wine, I was a scotch drinker. I started praying that I would get home safely, actually I prayed all the way home that I wouldn't buy that wine. I called someone in the program as soon as I got home... The intensity, the sweating, feeling uncomfortable in my stomach, the hair raising on the back in my neck. Or to be in some place and smell alcohol, or smell of marijuana, it would be the same thing, I would get sweaty, it would be physical, just that strong euphoric recall.

Several of the participants stated that their cravings diminished over time as they progressed in their recovery. An interesting example of this is the following:

After treatment, the cravings were horrible. I think because I kept the ace in my back pocket, that alcohol was still an option. That if it got bad enough, that I could drink, and that I would be able to safely make it back. So when I would crave, it would be consuming... I romanticized it, and thought it would take the edge off, and nobody would know... The cravings after I surrendered were different, they passed pretty quickly because they were no longer an option. I would take action. I would call somebody... A lot of the pride had fallen away, and the desire to stay clean was a polar opposite to what it had been before.

Question twelve asked the participants what social support they had during the first year of recovery. Table 6 shows how this question was answered in each group:

**Table 6**

**Variation by Group for the Question "What Social Support Did You Have During Your First Year of Recovery?"**

Category	Group Percentage		
	AA	TX	SR
Family support	17	40	25
Other recovering people and non-using friends	25	20	38
Alcoholics or Narcotics Anonymous	33	10	0
Sponsor/mentor/counselor	25	10	13
Church or church related activities	0	10	13
Work or support of employer	0	10	13

Support for the AA group, as expected, clustered around AA/NA and related activities. For example, if the response rate for AA or NA, sponsor/mentor/counselor, and recovering friends are combined, the response percentage of the AA group increases to 83%.

The previous literature had suggested that family is a key element of support (Granfield & Cloud, 1996) for SR's. As Table 6 shows, this was not the case for this study. One explanation for this is that, in the Granfield and Cloud study, the sample was made up of middle class participants. The current study

was made up of a large percentage of participants who identified more with a lower socioeconomic class. The SR's in this study relied heavily on church-related activities and non-using friends for their support. Only one member of the SR group cited family as a source of support.

The following are two participant responses that show varying examples of support. The first response is from an SR participant:

My best friend from high school. She was my roommate in my first year in college. She was a true friend and we really connected and I could talk to her. She was the first person that I shared my story with. She didn't really know, she knew I had been a bit of a wild child and stuff like that but she did not know the extent of it. I was able to tell her it all, piece by piece, and that was really helpful to me. And there was this group of girls in the dorm that I started to hang out with who belonged to this youth group at this church. I would hang out with them and go to their youth group and that was kind of cool for me to be with, I didn't have to deal with the pressure of being at a party and not knowing what to do.

The following response is similar to other responses from the AA group:

Mostly it was meetings and people I met in meetings. We did a lot of stuff together, we would go camping together we would have progressive dinners together. I was very fortunate at that time there was a core group of us in my circle of friends who had gotten sober at about the same time. They all stayed sober, so when I made it back after my last relapse, I had some good support and modeling.

As a person learns to manage stress more effectively, they also begin to decide how to live comfortably in sobriety. This is an important part of stress management. Theme Four captures how many of the participants accomplished this task.

*Theme Four: Learning to Live a Sober Life.* Learning to live a sober life means that for recovery to continue, the participants had to learn how to not just be abstinent, but to be comfortable without their drug of choice. This is the last

**theme of the *Adjustment Phase*. Learning to live a sober life happened for most of the participants as they became more confident in their ability to stay away from their drug of choice and other self-destructive behavior. This theme was about understanding that their recovery was dependent on their ability to learn how to live comfortably in sobriety. Most of the participants admitted that they initially felt very unsure that they could ever feel as good not using their drug of choice as they once did under its influence. But, the participants also admitted that the high they had gotten from their drug of choice had long since been replaced by using their drug of choice primarily just to not feel bad. Many of the participants claimed they were looking for relief from the pain that their drug was causing. But slowly they began to gain hope that they may eventually begin to feel well again. They did this in a number of ways that more or less translated into learning to accept responsibility for their actions, handling problems as they occurred, and living in the moment. As one participant stated, "I have learned that stress resides in the past and the future, it does not know how to be in the present – when I can be in the present I am not stressed." For others, this understanding came from the second step of the 12-steps of Alcoholics Anonymous "Came to believe that a power greater than ourselves could restore us to sanity." As one participant explained it, "If you want a laugh, tell God what your plans are." And another stated, "I needed to learn to pray for potatoes, but I had to be willing to pick up the hoe, and most importantly, I had to sometimes accept carrots or onions when I really wanted potatoes." Each participant seemed to make peace with substituting their desire to be the sole director of**

**their life as opposed to being an active co-participant, in some cases with their higher power, and in other cases with their significant other or other important people in their life. As one participant stated, "In my addiction I was God, but in my recovery I am just me, and just me is so much easier."**

**Social support greatly contributed to the ability of the participants to make the transition to living a sober life. For the AA group, this theme primarily came from the steps of AA/NA, their sponsor, the literature of Alcoholic Anonymous and Narcotics Anonymous and other recovering individuals. For the TX and SR groups, this understanding came from such diverse sources as "my wife," in one case, to spiritual orientation factors in 6 of the 12 participants in these two groups. This spiritual orientation ranged from strict adherence to Christian beliefs to a more "other" centered, (vs. self-centered) orientation of respect for the earth. And as previously mentioned, five of these twelve participants from the TX and SR groups attributed their support to family.**

**For all of the participants, "Learning to Live a Sober Life" came over a period of time. For some it occurred within the first year of recovery, but for others it took several years. One spontaneous remitter stated that "for several years" he was sober, but recovery came when he began interacting with co-workers who were in a more traditional form of recovery. He went on to explain that he never attended 12-step meetings (Alcoholics Anonymous), but his co-workers were excellent role models and, through what he learned from them, he was able to incorporate some of the ideas of AA recovery with the support and knowledge he received from his prayer and bible group and from his counseling**

**education that centered on a cognitive-behavioral orientation. For him, in other words, his ability to handle stress and learning to live a sober life came from several sources. This tended to be true for most of the participants regardless of their group.**

**The theme “Learning to Live a Sober Life” was developed from the categories that emerged from question 10, which asked, “In what ways do you currently reflect on your early days of recovery?” and question 11, which asked, “What significant events occurred in the first year of recovery that were difficult for you?” and question 13, which asked, “At what point in your recovery did you begin to feel good about not using your drug of choice?” The following are several quotations from participants that help in understanding how the theme “Learning to Live a Sober Life” emerged. As these quotations show, “Learning to Live a Sober Life” was a process that consisted of a change of perspective concerning what was important. For all of the participants, the first year of recovery was a period of learning that was often difficult. Even years later, most of the participants reflected on the learning of that first year or so.**

**Question ten asked the participants in what ways they currently reflect on their early days of recovery. Four of the seven SR participants stated that they do not reflect on their recovery at all. Two of the five participants in the TX group indicated they did not reflect on their early recovery, and all five participants in the AA group stated that they did reflect on their early recovery. All of those who stated that they did reflect on their early recovery stated that they felt this was helpful, as illustrated by this SR participant:**

**It's funny, I do think about it, I do. One thing that I do is that I write poetry, and a lot of the thoughts that I didn't know really how to express then, I can express now. It's like now I can express them through my writing, and that helps me. I think something good did come out of that time. I think I understand how other people feel. I know what it's like to feel so low, and you so alone. I can express something through that time now. It's not like a bad thing when I think about it, but I do think about it.**

**And an AA participant expressed her view this way:**

**I was totally out of control. I was in much worse shape than I thought I was. I knew I was in bad shape, but I didn't know how bad it was, and that has given me the compassion for my own clients. I know what it is like, being in an early early-stage, being in a mess. I know for me, information was coming in and the light bulbs were not going on, until much later. You hear but you don't absorb because you don't remember, but later on things in the program, the slogans the experience, ah ha, now I know what they meant, because it will happen. I think it is important that I do not forget.**

**Sixteen out of 17 participants identified at least one difficult event in their first year of recovery that they had to manage in a sober manner. Several identified more than one event. The one person who could not identify an event was an SR. Most of the problems were "living" problems such as losing a job, or concern over an ill parent. These problems, for the most part, caused a great amount of stress that added to an already stressful situation. Two examples follow: "My wife had left with my child and I didn't see my wife or my child for about two and a half years. I didn't know where she was with my little child. I went through a lot of things, my father was having medical problems my mother was worried to death. I had a lot of family issues." And, the following quotation also points out the difficulty many recovering drug addicts and alcoholics experience in early recovery:**

**Not having any income and not having a job. I hadn't had a job since I was 16 years old and after that I went into using...I didn't know how to get a**

**job and I didn't think anybody would hire me or take a chance with me...I had a mom that loved me and shared with me but I was a grown woman. I had been out on my own since I was a teenager and I just wanted something I could call my own...The way I knew how to get money was hustling and I knew that would take me back into drugs. I constantly went to meetings and when there was not a meeting at my church I went to bible study. I stayed there every single night because I was just afraid to go back out into the world - the transition was very difficult.**

**Question 13 asked the participants when they began to feel good about not using their drug of choice. The answers fell into two distinct temporal categories: "early on", and, "it took some time." Eight out of seventeen participants stated that it took some time, and eight out of seventeen stated it was early in their recovery. Each of the three groups was close to equally split between these two categories. The following is a response from a participant who stated that it took some time: "Probably about the fifth or sixth year. There were a lot of things in my past I had to clear up and a lot of issues I had not dealt with. There were a lot of things I had to say I'm sorry for. I did a lot of apologizing and a lot of work. I wrote a lot of letters to people."**

**The following is a response from an SR participant who did not fit either category: "I don't think I ever felt good or bad it was just something that I did. Drinking was just something I don't do any more. I am a very structured person, I guess I plan my existence and I plan my days. That is how I approached the whole thing - I need to quit drinking and I'm going to quit drinking and I did quit drinking. " A typical "early on" response was, "I felt good right away, about not using, even though it was hard sometimes."**

**As these quotations illustrate, "Learning to Live a Sober Life" took some time and was not easy. Due to the stress of the change and the associated pain,**



relapse occurs for many recovering individuals during the *Adjustment Phase*. Both Chapter I and Chapter II of this study detailed the reasons for this. Relapse did occur for the eight participants of this study. Although this theme was not universal for the participants, it is a common occurrence. Themes five and six comprise this *Relapse Phase*.

### *The Relapse Phase*

As mentioned, eight of the seventeen participants experienced a relapse. Approximately half of the participants of each group relapsed, and six of the eight relapsers' drug of choice was a drug other than alcohol. Of the eight who did relapse, six reported less severe relapse episodes as compared to their addictive usage, and two reported more severe usage as compared to their active addictive stage.

Three questions were asked of participants who experienced relapse. There seemed to be a general sense that the relapses that occurred were thought of by the participants as part of their recovery process. Only one participant experienced their relapse as being negative. This person also stated that her drinking was more severe with each of her three relapses. Two themes emerged from this stage.

*Theme five: Determining the Cause of Relapse.* Relapse is often a part of the recovery process. This is especially true when learning is the result of a relapse. All eight participants who relapsed were able to state the cause of their relapse. The reasons these participants reported were the following: negative emotions or self-image, response to cravings, or response to drug taking

triggers. Four participants stated that drug-taking cues or triggers initiated their relapse, two participants stated that cravings triggered their relapse, and two participants cited negative emotions or self-image. Although the causes of relapse were not probed to a great extent, several of the participants reported being in an anxious or stressed state when the relapse occurred. One participant offered this explanation: "The first one (relapse) was to make sure I was really an alcoholic, the other two were under times of stress." Other quotations that explained the participant's relapses included cravings in addition to a negative emotional state are illustrated by this quote, "It was just something within myself that I didn't know how to deal with, maybe it was a little bit of depression, that I needed something to help me get through. Cravings were part of it too, sometimes they were very bad." And, non-acceptance of one's addiction and one's sexuality is illustrated by this quotation:

The first couple relapses were because I'd simply did not believe that I was an alcoholic. That was pretty clear-cut. But, the last one, I would say 95 percent, was related to my trying to come to terms with my sexuality. I had just not come out. I was just fighting all of that, and could not come to terms with it. That relapse was about just giving up saying forget it, this is just how I'm going to live.

Although the last quotation shows how dramatic the cause of relapse can be, the remaining quotations show that it is often related to just not feeling so well, or acting on a thought or feeling, as illustrated by the following explanations: "Most often it was just being with family or friends that drank or used, it was always getting in a situation and making a poor choice," or "Stress and loneliness triggered my relapses," or "Bad Feelings and situations that feel like they are uncontrollable." These examples show that relapses have a great many

**determinants. What was common for the participants of this study was their ability to use these relapses to move forward in recovery by learning from them.**

**Although a relapse often results in negative consequences, for these participants, it did not. As often is the case, relapse is a learning experience that can have a positive outcome by “responding to the Relapse” which is the next theme.**

***Theme Six: Responding to the Relapse.* The second theme to emerge from the relapse process was that the participants successfully responded to the relapse. This meant that both a cognitive understanding of the relapse was coupled with an action to prevent further relapse. For the participants of this study, the relapse episode was generally short in duration and the usage was not severe.**

**It seems that learning did indeed take place as a result of the relapse. Several of the relapsers stated that the relapse helped them to weigh the evidence whether they were indeed an alcoholic or drug addict. For example, two participants stated that, even though they felt they were an alcoholic or drug addict when they commenced their abstinence, as time progressed, they became less convinced. One participant put it this way, “I was convinced I was an alcoholic, I just was not convinced I could not drink.” In all but one case, the relapse or relapses made it more difficult to refute their ability to control their usage. Learning did take place that contributed greatly to their recovery.**

**Another way that the theme of successfully responding to the relapse emerged was in what the participants did to end the relapse. In half the cases,**

the participant took some sort of direct action, such as using relapse prevention strategies or seeking help. For the other half of the participants, the action taking was less direct, such as staying away from specific people, settings or, circumstances.

All of the participants spoke of how fortunate they had been in that they were able to stop the relapse episode and resume their recovery. All shared that they were aware that relapse often culminates in a very bad outcome.

There did seem to be a difference in who relapsed based on group membership. Relapse was more common for the AA group and least common for the SR Group. Of the seven SR's, only two experienced a relapse, whereas two of the five participants in the TX group relapsed and four of five of the AA group relapsed.

The following is an example of a TX participant who relapsed:

One of the first things I did was I told my counselor. He helped me come to the realization that it was easy for me to stop using. The awareness that came is that staying stopped is the problem. When that really kicked in, that if I am really going to do this I'm going to need to not just stop, I need to stay stopped, it seemed to work. That was almost 15 years ago.

Another example is an SR who relapsed: "I would feel guilty about the relapse, I would know I was doing the wrong thing, I began to take responsibility." In some cases there were multiple relapses, but for all, there was, by definition, the final relapse. For the participants in this study, since their last relapse, they have had a long stretch of recovery in which their life has changed substantially. The last five themes describe how this change took place.

### ***The Transformation Phase***

The last phase of recovery is termed the *Transformation Phase*. This phase encompasses the life-long changes in personality that develop as a result of the recovery process. There were five themes associated with this phase. These themes closely paralleled and built on the themes associated with the *Adjustment Phase*. Each participant was asked three questions concerning the key influences on their recovery. These last five themes were constructed from the categories that emerged from those responses.

Tables 7, 8, and 9 relate to the categories developed from question 17. This question asked the participants, "How would you explain your recovery when others you have known have not been successful?"

This question was key in understanding the process and themes of recovery for the participants and was instrumental in constructing the last five themes. Table 7 shows that there is some variability between the groups for question 17. If the categories are collapsed further into internal factors and external factors, the difference in groups becomes even more noticeable. This result is shown in Table 9. This was accomplished by combining the following categories to external factors: "God/spiritual assistance" with "external/environment factors." The categories of "gratitude," "introspection/self-reflection," "logic," "motivation/willpower/commitment," and "belief in self" as internal factors.

Table 7

Categories for the Question "How Would Explain Your Recovery When Others You Know have Not Been Successful?"

Category	Percentage of responses
God/spiritual assistance	25
External/environmental factors	23
Introspection/self-reflection	18
Motivation/willpower/commitment	15
Logic	7
Gratitude	5
Belief in self	7

Table 8

Variation by Group for the question "How Would You Explain Your recovery When Others You Know Have Not Been Successful?"

Category	Group		
	SR	TX	AA
God/spiritual assistance	23	23	30
External/environmental factors	30	7	30
Introspection/self-reflection	7	23	23
Motivation/willpower/commitment	15	23	7
Logic	15	7	0
Gratitude	7	0	7
Belief in self	0	15	0

**Table 9**

**Variation by Group in Percents When Categories Are Collapsed to External and Internal Factors for the Question "How Would You Explain Your Recovery When Others You Know Have Not Been Successful?"**

Category	Group		
	SR	TX	AA
External Factors	53	30	60
Internal Factors	47	70	40

Table 7 shows the categories for the question "How would you explain your recovery when others you know have not been successful?" Table 8 shows there is a rather even split between external and internal factors when participants answered the question "How would you explain your recovery when others you know have not been successful?" As Table 9 shows, when the internal and external factors are collapsed and broken out by group, there is some variation. The AA group is the most externally oriented group, with 60 percent of their responses falling in the category. The TX group is the most internally oriented group with 70 percent of their responses falling in that category. The SR group was fairly evenly split with 53 percent of their responses being external factors.

*Theme Seven: Facilitating Change Through Spirituality.* This theme was important for ten of the seventeen participants. "Facilitating Change through Spirituality" is defined as using an active relationship with God or some other spiritual phenomenon to assist in the transformation of personality from the self-

centeredness of addiction to a more open and empathic capacity. This spirituality manifested in several different ways. The use of spirituality, as would be expected, predominated in the AA group, with four out of five attesting to its importance. For the TX group, three of five spoke of its importance. It is noteworthy that these three felt that NA was not spiritual enough; thus all three left NA after participating for only a short period of time and became very involved in their churches. All three of these participants made it clear that their churches were how they manifested their spiritual journey, and that their church participation was not just a religious exercise. One of the these TX participants explained her sense of spirituality this way, "I do not believe that I did it by myself, I believe beyond a shadow of the doubt that God helped me, and I believe that God put his hand on me. He had a reason for keeping me living; he had a reason for bringing me through all that."

Three of the seven SR's were heavily involved in facilitating their change through spiritual means. One SR put it this way, "...but my faith in God, that has been the marked difference, in my enjoying - in the quality of my life. Yes I was staying clean, but there was still an amount of hopelessness, and depression, and ways about me, and my character, and patterns that I could not escape, my spiritual decisions have made all the difference, I have been freed..."

The last quotation supporting this theme was from an SR participant. This quotation demonstrates that spirituality did not always manifest itself through a religion. This participant supported her recovery with "Activities that connect me



**with the Earth and all living things. Spiritual rituals, daily and seasonal, and meaningful and regular meditation.”**

**It should also be noted that the participants were never asked a question concerning their spirituality. Each of the ten spoke of their spirituality without a prompt or probe.**

***Theme Eight: Facilitating Change Through Community Support.* This theme relates to living in and receiving support from the broader community such as friends, the recovering community, vocation, education, and leisure related relationships and activities.**

**Twelve of 17 participants connected their recovery to the support or involvement related to this theme. These twelve participants included all five AA participants, two of the five TX participants, and five of seven SR participants. This theme varied in how it manifested itself. If examined closely, the meaning that participants gave to this theme may have overlapped with AA or NA support, support of religion, and possibly even support of family. For example, several participants attributed their continued growth to their “support system.” This should have been probed, but was not. It can be inferred, however, that their support system most likely included elements both inside and outside their families, AA or NA, or their spiritual support system. However, several of the participants made it very clear that their support system included their non-using friends who understood and accepted them and from whom they learned. One SR participant stated it this way: “The activities I was involved with, the friendships that I made were so helpful in my finding my way. I received**

unconditional understanding from them – they accepted me in way that I always wanted.” Three participants spoke of how changing their work environment was instrumental in their change process, as illustrated by this quote from one of the SR participants:

**My situation was one where I had a chance to change jobs. Had I not changed jobs I think it (recovery) would have been more difficult for me. There was a willingness to take a risk, to look for another job. A lot of things came together at that point – getting away from that environment (previous work environment) that I had been so involved in was very helpful.**

For all three groups, participants used the normal activities of leisure, employment, neighbors, roommates, and friends to support their continued growth and transformation.

*Theme Nine: Facilitating Change Through Family Support.* When asked the question, “As you reflect on your recovery, what specific factors made your recovery possible?” eight participants responded in terms of the support of their family. This theme was not universal between groups, however. Only one of the AA group cited family as a factor. Four of the five participants of the TX group cited family as a factor and three of the seven SR’s cited family as a factor. One AA participant stated that “AA had become my family of choice.” This was because of severe addiction within her family of origin. Only two participants shared that they currently had very little support from their family (one AA and one SR participant). Others who did not cite family as a factor also may have had fractured family relationships. This may explain why only one of the AA participants cited family as influence. AA/NA, in many ways, can serve as a surrogate family and might appear attractive to those who felt that they had very

little support from their own family. One SR participant stated that his mother went to her grave not accepting his alcoholism. The following quotation shows how non-supportive family can be. This participant was 16 years old when she overdosed. She reported, "In my family treatment wasn't really that much of an option, it was a shameful thing and stuff. It was like, you brought this on yourself, get over it. I needed their support, and I didn't have that...I felt really alone." This participant had to struggle with her addiction without any formal treatment or support other than her non-using friends and later the support of a church youth group.

A positive example of support from family is the following quotation from an individual who had a long history of addiction, "My mother and my father standing behind me. Everybody else had given up on me. I had been incarcerated so many times. I had no support network. I had my mother, she kept believing in me. She was my one stronghold. I'm not sure my father even believed in me." And for several participants, their spouse was supportive, as illustrated by this quotation, "I think if I had to choose one thing it would have to be my wife I probably gauge 90 percent of my sobriety on her - she was that supportive."

For the participants of this study, nearly half stated that family support was critical. But there was evidence that the converse, ie. family as a deterrent, was also true. As previously stated, only two participants openly suggested that their family was not supportive. A direct question concerning family support was not

asked, so any assumptions concerning the non-support of family are only speculative.

Support of family is only one of five themes of the Transformation Phase. Although support of family is important, and non-support often times problematic, the other themes of this phase, for the participants of this study, compensated for family support. The last two themes were evident in the two participants who stated that their family was non-supportive.

*Theme Ten: Facilitating Change from Within.* This theme is defined as the use of motivation, a strong belief in one's own determination, and willpower to facilitate change. However, for virtually all of the participants, there was initially a need to be led, or to be shown the way. For some, this lasted for a very short time, and for others this was a recurring theme. Most participants did verbalize that as much as they appreciated the support of others, the answers to their problems ultimately came down to themselves. Fifteen out of seventeen characterized their change to a "willingness" to change or their "motivation or willpower." Several participants made statements such as "it is an internal struggle, taking the shame off and taking responsibility, and not blaming others," or "I was pretty self-reliant, I was very determined, I feel very strongly that it is up to the individual," or "we were willing to take the risk to make the changes necessary." Most were emphatic that the important work to change and to complete the journey of transformation had to be sustained by the individual – that motivation, willpower, introspection, and determination were the tools of the trade of recovery. The following two quotations illustrate these points:

**It has been an evolving process. It is an internal struggle, taking the shame off and taking responsibility, not blaming others. My addiction is because of my family, or it is because of this event or that event or heredity, and all that stuff. I think we have to go there, but I think where we finally need to end up is, somewhere somehow, taking responsibility, and say yeah crappy things happened, how long am I going to wear that as an excuse to continue my addiction.**

**And, "I would think the level of gratitude and the real depth of my bottom. That was as far as I wanted to go. And realizing what I had to lose, also knowing that alcohol caused me difficulties in my first marriage and my second was going the same way. I just didn't want that to happen again."**

**Logic was a subtheme that came up for four participants. Three of these four were from the SR group with the other from the TX group who rejected AA within the first ninety days of recovery because it was not logic-based. The following quotation is an example of logic:**

**I think we are all responsible for our own behavior good or bad and the consequences of that behavior... My success, I believe, is based on logic. When I start to think it through, I develop techniques to stop the thinking. If I find myself upset or holding a resentment I say why am I doing this and I have a nice conversation with myself and I keep reducing my answers down to the bottom line...so I go back I cranked it down to logic. Well because that yahoo cut me off on the way to work this morning. That is why I am successful, it is using logic. I am taking responsibility for my behavior. I have a free will in what I choose to do - it is up to me.**

**Another subtheme related to the theme of "Facilitating Change from Within," is the act of service to others. Only five participants cited this as important for their continued recovery, but those five individuals felt that their need to give back came from within and it was a very strong need. Four of these five were from the AA group, which makes sense, since service to others is an important aspect of AA and NA. The following is a quotation from an AA**

participant, "...a strong responsibility to try to help others, it's a value for me, it's a selfish motive, but it is a value I have to maintain. It also it feels good, it just makes me feel whole, I just have a sense deep inside a me now. I did not create all of these events in my life...I'm here to use them...that is what it's really about to help someone else..."

As this quotation shows, this participant felt the need deep inside to give back. There was a sense from all five participants who cited this factor, that to not serve others would be selfish. Providing service to others was seen by all five participants as a profound act of caring that they wanted to do.

"Facilitating Change from Within" was an important theme for all but one participant. Although this theme manifested itself in different ways, the common thread in this theme was that the participant took action and responsibility for her or his transformation.

The last theme of the *Transformation Phase* is related to the use of external supports. This theme was also named by a majority of the participants, often in concert with internal factors.

*Theme 11: Facilitating Change Through External Supports.* The categories that determined this theme were reported by nine of the participants. This theme is defined as the use of such things as, strict adherence to a "program," luck, counseling, or the environment, to facilitate the change process. This theme took the form of seeking professional counseling for three participants. Also, three participants stated that their job or the ability to have a good job was extremely beneficial in the transformation. Two participants

attributed luck in how things simply happened to allow them to grow and develop and one participant attributed her change to following a set of guidelines (AA). This theme of “Facilitating Change through External Supports” occurred more often for the AA group and TX group, but two of the seven SR’s also attributed the use of external supports as the reason for the success. The following is an example of how one SR participant attributes her recovery to a change of environment:

I went back to California and I saw how many of my friends have gone down, living on the street, nowhere to live, living in a van, total addicts. I'm so thankful that I moved from that town. I think it does have a lot to do with environment, because when I moved, I was exposed to a whole different group, and different activities, the kids in my new school were not into getting high, I think that is why I was able to get away from it.

The following quotation relates to education and employability: “I think number one was education, being able to work, and the jobs I was able to have, to earn income and have an interest in what I do, I could not be a big-time substance abuser...”

For most the participants of this study, external supports were important. Several of the participants who predominantly used logic, self-determination, or other internal supports also stated the importance of external supports. An example of this is the following two quotations:

In it was the education I got in treatment and it was changing people places and things. It also was remembering how bad it was. Changing my whole mind, my whole paradigm if you well, from someone who is thinking that what I am doing is OK, that drinking and drugging is OK, to someone who says this is a big mess, this is a big mess that will end badly. That involves a mind change, this is not me anymore this is not who I want to be anymore. It is like a decision between life-and-death. When you get right down to it, you know, you are committing little suicides with each needle and with each drunk.

And,

**That it's ongoing, it is an ongoing process. Change does not end. There is no destination. I expect to have hard times, I expect to have turmoil, I expect stages, and I expect to have answers and solutions based on the 12-steps and my willingness to look deep inside my soul. I have grown a lot spiritually, that's never-ending, it just keeps going, and it is an exciting journey, not one that will end. I had a second chance at life as a result of it, why would I want that to stop, it has been too wonderful.**

**Both of these quotations show how the external supports of "It was the education I got in treatment," or "Solutions based on the 12-steps" co-mingle with change from within such as "Changing my whole mind, my whole paradigm," and "My willingness to look deep inside my soul."**

#### ***Summary of the Process and Themes of Successful Recovery***

**The purpose of this section was to summarize the findings regarding the Process and Themes of Successful Recovery. This was accomplished by applying the findings to the first research question which was, "What are the processes and themes of recovery from chronic use of psychoactive substances?" This question was answered by the analysis of the answers to the 20 questions given by the 17 participants. The analysis revealed 56 categories that comprised the 11 themes and four phases of recovery. These four phases describe the Multimodal Process of Recovery (MPR). Below is a brief summary of the MPR.**

***Summary of the MPR.* The participants of this study experienced either a single event or more often a series of events that created a desire for them to *initiate* the change process (Phase 1). This was accomplished by "Acting on the Need for Change," and "Internalizing a Desire for Change." Once this change**



process was initiated, the participants had to manage their life differently. This was called the *Adjustment Phase* (Phase 2). In this phase the participants had to "Learn to Manage Change and Stress" differently and "Learn to Live a Sober Life." After the *Initiation Phase* or the *Adjustment Phase*, nearly half of the participants experienced a relapse (Phase 3). For these participants they experienced the *Relapse Phase* in which they successfully "Determined the Cause of Relapse," and "Responded to the Relapse" effectively. The last phase of the MPR was the *Transformation Phase* (Phase 4). During this phase the participants continued a significant personality transformation through a combination of the following ways: "Spirituality, Community Support, Family Support, Internal and External supports."

The following quotation illustrates much of the MPR:

... I think, there has been a little bit of luck involved. I had been lucky that I did not crave it. Along with that is the realization that life is worth living, it is going to be a lot better, to live if you enjoy it, with a sense of reality instead of saying I can't put up with this I'm just going to numb out. I accepted the fact that life was good and things kind of happened along the way. I think long-term rehab, in a residential rehab, had a lot to do with that...One of my big fears was, that I would never enjoy life without a can of Budweiser in my hand...at least in the short-term life could be very, very unpleasant. When I was in jail I detoxed close to a case of beer, and shooting 1 1/2 or two caps of heroin a day, and three packs of cigarettes. I went from that to nothing for a week...I thought that there would be no more fun...that nothing would be OK. But it has turned out to be pretty much a riot...I think that those who do make it do because of good incentives...I don't think any of the four of us who made it have been big AA or NA people. I can't speak for that. I think the difference was, is that we had the support, and the incentive...we were willing to take the risk to make the changes necessary. I think those that did not make it, that OD'd, they didn't get it they didn't get the seriousness of the jail, institutions, and death part. That you will be wearing the orange jumpsuit or you will be in the coffin, or you will be in Eastern State, and it will not be fun. You have to get that piece of it. And another thing I always tell people is, do the right thing, you just have to do the right thing. It is really that simple...

Although this was a direct quotation from one of participants, it was very similar in content to the stated thoughts of most of the other participants. This quotation clearly shows the *Initiation, Adjustment, and Transformation* phases and most of the related themes. An additional quotation from the same participant is also representative of the contrast between how the participants perceived themselves in addiction and how they perceive themselves currently:

I see myself as a much better person a much greater person, more moral, and I feel better about myself, I feel more civilized. I am not ashamed about what I was. With us addicts, there is a sense of false pride, that went with being the best addicts in the world, and you don't often look at yourself as the scum of the world like everyone else does. You have to kind of fool yourself there. I'm not packed with self-esteem, but I do like myself now a lot better. I see myself as contributing.

This quotation gives a sense of the change that is produced and is indicative of all of the participants. The MPR and associated themes describes how this change occurs regardless of whether the participant used AA or NA after treatment (AA and TX groups) or they spontaneously remitted. The next section will examine the results in terms of the differences in these groups.

#### *Differences in the Processes and Themes Based on Groups*

The second research question asked whether the processes and themes were different for the three groups (AA, TX, SR). The following is discussion of the findings of this study in answering this question.

The process of recovery in terms of the stages was the same for all three groups. Table 10 shows how the themes varied between groups.

**Table 10****Variation in Themes by Group with Number of Participants**

<b>Theme</b>	<b>Number in Group</b>		
	<b>AA</b>	<b>TX</b>	<b>SR</b>
<b>Acting on the need to change</b>	<b>5/5</b>	<b>5/5</b>	<b>7/7</b>
<b>Internalizing a desire for change</b>	<b>5/5</b>	<b>5/5</b>	<b>7/7</b>
<b>Learning to deal with stress and change</b>	<b>4/5</b>	<b>5/5</b>	<b>5/7</b>
<b>Deciding to live life on life's terms</b>	<b>5/5</b>	<b>5/5</b>	<b>6/7</b>
<b>Determining the cause of relapse</b>	<b>4/5</b>	<b>2/5</b>	<b>2/7</b>
<b>Responding to relapse</b>	<b>4/5</b>	<b>2/5</b>	<b>2/7</b>
<b>Facilitating change through spirituality</b>	<b>4/5</b>	<b>3/5</b>	<b>3/7</b>
<b>Facilitating change through community support</b>	<b>5/5</b>	<b>2/5</b>	<b>5/7</b>
<b>Facilitating change through family support</b>	<b>1/5</b>	<b>4/5</b>	<b>3/7</b>
<b>Facilitating change from within</b>	<b>4/5</b>	<b>5/5</b>	<b>6/7</b>
<b>Facilitating change through external supports</b>	<b>4/5</b>	<b>3/5</b>	<b>2/7</b>

As table 10 shows, there was some variability between the groups. When looking more specifically at the categories, the differences become more obvious.

***Differences Between Groups in Stigma Associated with Treatment***

An examination of the composition of each group suggests differences in recovery themes. For example, the SR group was made up of individuals who were once addicted to a psychoactive substance, who had five years of abstinence, who did not receive professional treatment for their addiction, and

who did not attend AA or NA to support their recovery. This group ostensibly quit on their own. All members of this group were aware of treatment opportunities and they were aware of AA and NA. In the SR group, two participants indicated that they needed and wanted treatment, but they did not know how to access treatment. Two others indicated that they would have considered treatment had they not been able to quit on their own, and two stated that they had been to an AA or NA meeting for someone else and felt that AA or NA was not consistent with their personality or values. For example, these two participants stated that they did not accept the concept of surrender and one participant did not see the notion of group support as being relevant for them. One of the most unusual cases consisted of a participant who stated that he had stayed abstinent for several years, but his recovery really commenced only after he began to understand the concepts of AA through several close friends who attended AA regularly. He stated that it was through their guidance and association that his recovery growth occurred, but that he never considered attending AA. He felt he would lose his sense of individual determination. Although a question concerning stigma and dignity was never asked, one participant of this group felt it was below his dignity to seek treatment or to attend AA. Members of this group did tend to stigmatize both treatment and AA or NA, and this may have been a reason they commenced recovery without attempting to use AA or NA or why they never sought treatment.

### ***Difference in Use of Logic***

**As a group, the SR participants were very self-directed and logical. For example, four of the five participants in the entire study who indicated that logic was a factor for their ability to recover were from the SR group.**

### ***Educational Level as a Difference***

**The SR group was different in terms of educational level also. Of the 17 participants in the study, seven were either currently pursuing or had already completed a Masters degree. Of the seven, five were in the SR group and of the other two SR's, one possessed a Bachelors degree and the other one was completing her Bachelors degree. This contrasts to the other two groups, who were less formally educated. Of the members of the TX group, two members had a GED, one had some college and the other two had a bachelor's degree. Of the participants of the AA group, two had a HS diploma, one had a bachelors degree and two had a masters degree. Also, the SR group, consistent with their education, was associated more with professional employment and, thus, with the middle class.**

### ***Understanding of Addiction as a Difference***

**The SR group also seemed to understand their addiction with more clarity than did the other two groups. The evidence for this exists in the answer to question four, which asked how convinced were they in treatment or when they stopped using their drug of choice, that they were addicted to their drug of choice. All seven members of the SR group said they were convinced. Such clarity contrasts greatly with the TX and AA groups and most likely made the**

***Adjustment Phase*** much easier. There is evidence for this in that only two of the seven members of the SR group experienced a relapse.

***Use of Spirituality as a Difference***

Another difference among the three groups studied lay in the use of spirituality in support of their recovery. As would be expected, four out of five AA participants attributed the spiritual aspects of their recovery as very important. Three out of five of the TX group felt this way, but only three of seven of the SR group indicated this. Since AA/NA places a great amount of importance on spiritual recovery, this finding does seem to be consistent. All five members of the TX group stopped attending AA or NA due to spiritual conflicts, although these conflicts were in two directions. Three of the TX group indicated that they desired a more religious orientation to their spirituality and two members of the TX group felt that AA/NA put too much emphasis on spiritual expectations and not enough responsibility on the individual.

***AA/NA Discontinuance as a Difference***

All members of the TX group had a great amount of exposure to AA or NA, but felt that their recovery could best be achieved through other means. There has been very little study as to why individuals stop attending AA or NA, but it is known that 50 percent of newcomers who attend AA stop attending within three months (Miller & McCrady, 1993). The current study suggests that this group (the TX group) would be worthy of more study to determine what other supports, successful AA/NA dropouts find effective. It is obvious that support can and does come from multiple sources.

***Conclusion on Differences in the Process and Themes Based on Groups***

**This study specifically shows that participants of all three groups can and do sustain quality recovery. There was very little observable difference in why the participants initially came into recovery. Participants in all three groups made enormous transformative strides in their five to 19 years of recovery. There was no discernable difference in quality or level of recovery based on how they obtained or sustained their recovery. What is different is how the transformation took place. For example, members of the TX group rejected AA or NA, but found alternate support in family, community, their faith or internal processes, or a combination of the above. Members of the SR group tended to be more self-directed, and possessed a measure of clarity that facilitated their transition from active addiction to recovery in a rather smooth manner. Finally, members of the AA group used spirituality more extensively than the members of the TX or SR group. Also, members of the AA group were more open in their interpretation of spirituality than were the members of the TX group who indicated that spirituality was a factor in their recovery.**

## **CHAPTER V**

### **DISCUSSION AND ANALYSIS**

#### *Introduction*

The purpose of Chapter V is to discuss the meaning and importance of the findings reported in Chapter IV. The importance of these findings will be organized in terms of their relevance to, first, theoretical and, then, clinical implications. This chapter will conclude with a discussion of the limitations of this study and suggestions for further related research.

#### *Theoretical Implications*

The following three overall theoretical implications will be discussed: 1) the emergence of the Multimodal Process of Recovery (MPR), 2) reasons for relapse, and 3) factors involved in spontaneous recovery. Each of these theoretical implications will be discussed in relationship to previous studies.

#### *Emergence of the Multimodal Process of Recovery (MPR)*

As reported in Chapter IV, a revised model of the process of recovery emerged. How this model is distinct from the models reviewed in Chapter II, and a comparison with those models will be discussed below. Before the MPR is discussed, the following two subsections will briefly discuss the difference in populations and intent of the current study, from which the MPR emerged, as compared to previous studies of the recovery process.

*Differences in Study Populations.* One major difference in this study and other studies that have produced a process of recovery, are the study populations. The participants of this study, as described in Chapter III, are a



rather heterogeneous sample of the recovering population who achieved their recovery in three distinct ways; 1) the use of AA or NA, 2) the rejection of AA or NA, and 3) spontaneous recovery. From the information available, the samples used in the development of both Brown's (1985) Developmental Model of Recovery (DMR) and Gorski's (1990) Process of Recovery are based on the traditional AA model and include alcoholics only. DiClemente, et al, (1991) Stages of Change Theory (SCT) was based on participants addicted to nicotine, and the sample used for Clemmen's (1997) Self-modulation Model was based on his clinical practice, which included both alcoholics and drug addicts. The present study used a more heterogeneous sample than the previous models and as a result, the emergent model indicates a more general process of recovery.

Additional evidence for the MPR being a more general model of the process of recovery is that this model encompasses three distinct methods of recovery. Other models have been based on more homogenous participants with a singular mode of recovery.

Another area of comparison of the MPR to other models of the process of recovery is that of the intent and method of the study. The next section addresses this issue.

*Differences in Study Intent.* The focus of the current study was to understand the processes and themes of successful recovery. Toward that end, very specific questions were asked of the participants to elicit what factors seemed to be important to their recovery. What this study did not specifically elicit was motivation or tasks related to the change process, as many of the other

models do. For example, Clemmen's (1997) Self-Modulation Model not only describes individuals' behavior in the various phases, but also explains motivation and assigns specific tasks to the various phases. Because of this difference, comparison of the characteristics of the phases will be most helpful.

*The MPR Initiation Phase.* The participants in the current study, while "Acting on the Need to Change" and "Internalizing a Desire for Change," which are the two themes of the *Initiation Phase*, demonstrated some of the characteristics similar to the "Contemplation" and "Determination" stage of DiClemente, et al. (1991) Stages of Change Theory. There is ample evidence in the current study that the participants, using DiClemente's words, "considered cutting back" and "weighed the costs and benefits" of change. These are characteristics of DiClemente's *Contemplation Stage*, in which the foundation for the change process is constructed. With the current study, the themes of "Acting on the Need for Change," and "Internalizing a Desire for change" serve the same purpose, which is to lay a solid foundation for the dramatic change to follow. The participants of the current study also made efforts to cut down or quit in a deliberate way, which are also characteristics of DiClemente's *Determination stage*.

The participants of the current study seemed to "weigh the costs and benefits" in two different ways. The first occurred as they were responding to the last humiliation or significant incident which led to the first theme, "Acting on the Need for Change." It occurred again as the gravity of their decision to quit was

felt. In both instances, the participants had to decide that quitting made more sense than the continued use of their drug of choice.

Also, for the participants of the current study, the *Initiation Phase* was just the beginning of a continuing process. Although DiClemente et al. (1991) describes a *Maintenance Stage* in his theory, he in essence states that after six months of success the individual simply continues to build on this success. DiClemente's model was developed from studying individuals addicted to nicotine. For the participants of the current study, six months was typically a time of great stress and challenge that manifested in the themes related to the *Adjustment Phase* of the current model. This perhaps indicates that the recovery process for psychoactive substances other than nicotine is different. This could be that the physiological dimension of nicotine is very high and the motivation of altering consciousness is absent with nicotine.

There was also some overlap between the *Initiation Phase* of the current study and the *Transition and Stabilization Stages* of Gorski's (1990) Process of Recovery. In the Gorski model, the *Transition Stage* commences as a result of the pain of the addiction becoming more difficult to deny. A common example of the *Transition Stage* is when a crisis related to use of psychoactive substances occurs. This crisis initiates a different dimension on the addict's thinking in how their drug of choice is impacting their life. The primary task of the *Stabilization Stage* of the Gorski model is to resolve the "presenting crisis" and to develop a realistic post-treatment plan to attend to the myriad of problems facing the recovering individual. The *Transition Stage* of the Gorski model is very similar to

the theme "Acting on the Need for Change" of the current study. However, the *Stabilization Stage* of the Gorski Model seems different from the theme "Internalizing a Desire for Change" of the current study. For the participants of the current study, there was a need for them to resolve the question of what it means to not have their drug of choice in their life. In the Gorski model, the *Stabilization Stage* seemed to be a more pragmatic matter. It neglected to consider the larger issue of what recovery means to the individual. This meaning question loomed large for the participants of the current study, with every one of the participants struggling with this issue.

There also existed some parallels between the *Transition Stage* of Brown's (1985) Developmental Model of Recovery and the *Initiation Phase* of the current study. During Brown's *Transition Stage*, the newly abstinent alcoholic or drug addict feels an overwhelming need to follow direction. This means that the recovering individual feels the answers to remaining abstinent lies in others less than oneself. For all participants of the current study with the exception of two members of the SR group, this was also the case during the *Initiation Phase*. Also, the more self-directed participants in each group of the current study progressed out of this phase rather rapidly, and began to rely more on their own instincts and experiences. This is an attribute that marks Brown's *Early Recovery* phase.

The last model of the process of recovery that has elements parallel to the *Initiation Phase* of the current study is Clemmen's (1997) Self-Modulation Model. Clemmens describes how in the early recovery a person will attempt to self-

regulate their behavior, but due to physical and emotional pain this is difficult without support. For the participants of the current study, support was also essential. It was used extensively in the *Initiation Phase* by all but one participant, and by 15 of the 17 participants during the *Adjustment Phase*, which will be discussed in more detail.

In sum, the *Initiation Phase* seems to be a more general explanation of the issues of early recovery. The *Initiation Phase* of the current study and the associated themes have some similarities to the four models of the process of recovery reviewed in Chapter II and discussed above, but none of the reviewed models encompasses all of the key features of the two MPR *Initiation Phase* themes. The *Initiation Phase* was universal among the participants of the current study regardless of whether they used treatment to assist them in cessation of their drug of choice or if they spontaneously remitted. The following section will examine the next phase of the current study, which is the *Adjustment Phase*.

*The MPR Adjustment Phase.* As discussed in Chapter IV, the *Adjustment Phase* and its associated themes expressed individuals' having to adjust to sobriety by learning how to manage pain and stress without a psychoactive substance and by beginning the change process to a sobriety based value system. This phase was universal for the participants of this study.

As mentioned in the above section, DiClemente's (1991) process of recovery did not address issues related to recovery after initial cessation. However, as with the *Initiation Phase*, there were several similarities between the

**MPR of the current study and the other reviewed theories of the process of recovery.**

**In the current study, the participants had to learn a new way of responding to stress. In Gorski's (1990) *Early Recovery Stage*, the tasks of identifying and interrupting addictive thinking, feeling, and acting, and learning non-chemical coping skills are somewhat similar to the tasks associated with the themes of "Learning to Deal with Stress" and "Learning to Live in Sobriety." In the current study, most of the participants verbalized how their whole way of living in the world had to change. Although unsure as how exactly to do things different, several participants stated that if what they were thinking and feeling felt familiar, it was probably wrong. This is very similar to Gorski's tasks of identifying and interrupting addictive thinking, feeling, and acting.**

**The participants of this study learned to be less impulsive and more self-reflective concerning their desire to use their drug of choice. Clemmens (1997) describes an *Early Recovery* task of being aware in the moment and thinking through the meaning of using the drug, and the inevitable consequences that have occurred before. This strategy was used by several of the participants in both the *Initiation Phase* and the *Adjustment Phase* and is very much a task of both "Learning to Deal with Stress" and "Learning to Live in Sobriety," in that, for most of the participants, the urge to use their drug of choice went on long after the *Adjustment Phase*.**

**During the *Adjustment Phase*, the participants of this study had already made a decision to try sobriety. Many of the participants felt that their drug of**

choice was no longer capable of helping them, and in fact, it was causing them significant distress. Ten participants shared that during their early recovery they actually felt worse than they felt while in the active phase of their addiction. While four of the participants relapsed during this period, six who experienced these negative feelings did not relapse. In the *Early Recovery Phase* of Brown's (1985) *Developmental Model of Recovery*, these feelings are explained as suppressed feelings from the past emerging. The participants of this study who experience these feelings handled them in different ways. Those different ways were related to the themes "Learning to Deal with Stress," and "Learning to Live in Sobriety." Most of the participants handled these negative feelings by believing that they would pass or at least become more manageable. Some participants took more direct action related to using stress management tools, and some participants relapsed as a result of these feelings. Virtually all of the participants revealed that they felt that early recovery consisted in great part of, learning how to manage many diverse feelings. The next section briefly discusses the *Relapse Phase*.

*The MPR Relapse Phase.* Although only eight of the 17 participants experienced a relapse, the potential for relapse remains great even into the *Transformation Phase*. Of the nine participants who did not relapse, all but two stated that relapse was often on their mind during the first couple of years of recovery (during the *Initiation* and *Adjustment Phases*), and all nine knew that relapse was an option. One participant with thirteen years of recovery stated that "The lure of alcohol very slowly diminished, but has never completely gone

away.” None of the other models of the process recovery incorporate relapse as a stage. Gorski (1990) addresses relapse as an event that can happen at any stage in recovery. The MPR of the current study indicates that, even though relapse was not universal for the participants, the possibility of relapse is high and should be considered as a part of the process.

For the participants of the current study who did experience relapse, the relapse was viewed by all as a part of their recovery process. None of the participants who relapsed, in retrospect, felt that they were a failure or that they had to begin the recovery process over again. In light of how all of the participants interpreted relapse as part of the recovery process and because the potential of relapse is so great, the *Relapse Phase* is an integral, although not universal part of the MPR.

*The MPR Transformation Phase.* During this phase, the participants of this study experienced an enormous amount of growth and change. All of the participants shared that the difference between who they were in their addictive state as opposed to who they had become in recovery was substantially different. The themes related to this phase of the model reported the factors that the participants felt facilitated the change.

Like the MPR's *Transformation Phase*, the *Ongoing Recovery Phase* of Brown's (1985) scheme states that there is continuing self-regulation and self-exploration, and that the use of external support takes on a new meaning. This was evidenced in the current study. Most of the participants of the current study had become very self-reliant (even the AA participants) and the use of external



support did have a new meaning in this phase of their recovery. For example, members of the AA group shared that their continued participation in AA was about giving back to others (service to others) and as one way to continue their personal growth. These participants also shared that their participation in AA during the *Initiation* and *Adjustment Phases* was about reducing anxiety and staying sober; now it was also about service to others.

Clemmens (1997) similarly describes a process of increasing awareness and involvement of interrelatedness, development of complementary rather than competitive relationships of the world, development of interpersonal competency, and being more involved in the world around through service and political action. These words describe many of the attributes and actions of the participants of this study as they progressed in the *Transformation Phase*.

*Concluding Remarks Concerning the MPR.* The Multimodal Process of Recovery (MPR) that emerged from this study is important because it describes a process that indicates a more generalized process for recovery than other current models even though it encompasses some characteristics of other models. Regardless of how the individual came to be motivated to change, and regardless of how they chose to pursue the recovery process, all of the participants in the current study progressed (with the exception of the *Relapse Phase*) in their recovery process in a very similar manner.

There are at least two theoretical implications of the MPR model itself. The first is that the MPR model presents a framework for successful recovery that is more general with regards to who is represented. This is different from

other models of the process of recovery in that this model generalizes the recovery process to these groups: individuals 1) who use AA or NA to support their recovery, 2) who stop attending AA or NA and 3) who spontaneously remitt. The second implication is that this model incorporates the concept that relapse can be a part of the process of recovery. This was true for the participants of this study. Although the idea that relapse can be a part of recovery is not a new idea (Gorski, 1990), it has not been previously integrated into a model of the process of recovery.

### *Reasons for Relapse*

A second overall theoretical implication of this study concerns the issue, and its attendant reasons, for relapse. As stated in the previous section and in Chapter IV, eight of 17 participants of this study experienced relapse after a serious and meaningful attempt to cease the use of their drug of choice. Although three relapse related questions were asked of the participants of this study concerning the cause of relapse, this topic was not probed to any depth, as it was not a stated focus of this study. Participants of the current study did cite the following reasons for their relapse: negative emotions or self-image, response to cravings, or response to drug-taking triggers. Several of the participants were in an anxious or stressed state when their relapse occurred. These findings supported the Environmental, Behavioral, and Affective models discussed in Chapter II, in that the participants of this study cited negative emotions or self-image, response to cravings, or response to drug-taking triggers. The Relational and Cognitive models, discussed in Chapter II, did not

seem to apply to these participants, in that none of the participants stated that negative thoughts or fractured interpersonal relationships caused their relapse. However, with additional probes and a more specific focus, there may have been evidence of these models as well.

### *Spontaneous Recovery*

The last theoretical implication of this study concerns the issue of spontaneous recovery. As discussed in Chapter I, the topic of spontaneous recovery has not previously been studied in depth except by Granfield & Cloud (1996) who studied 46, middle-class spontaneous remitters.

The spontaneous remitters of the current study revealed four important characteristics: 1) the clarity they had concerning their addiction, 2) the determined desire they had to overcome their addiction, 3) their overall attitude about addiction, and 4) their access to adequate support. Each of these characteristics will be discussed in relationship to the previously reported literature on this subject.

*Clarity about their Addiction.* As reported in Chapter IV, the members of the SR group had very little difficulty understanding that they had a problem with their drug of choice, that is, they had clarity about their addiction. Some SR members came to this realization early and some later, but once they understood that their use of alcohol or drugs was a problem, they experienced very little ambivalence. The exact reason for this is unclear, but initial speculation revolves around the factors of maturity, education, and a possible dimension of personality worthy of further investigation. For example, personality factors might

enter into the case of a member of the SR group who was only 16 when she commenced her recovery. This person was addicted to methamphetamines as her drug of choice, but used several other drugs frequently as well. Based on her age and extensive involvement with drugs she would not have looked to be a good candidate for spontaneous remission. In fact, her recovery was difficult but nonetheless successful. In her case, recovery was most likely due to her clarity, which was possibly based on a personality dimension and on the next characteristic to be considered, which was her determined desire to overcome her addiction.

The previous literature did not specifically suggest that clarity is a factor for spontaneous remission. However, The findings of Ludwig (1985) cited "personal crisis" as the reason spontaneous remitters quit. This finding was verified by this study. Also, the Ludwig group cited no desire to drink and willpower as the reason they continued to not drink. Both the reason they quit and the reason they did not resume drinking parallel very closely with the responses of both the SR group and the TX group of the current study and may suggest the participants of the Ludwig study did have clarity about their addiction.

Walters (2000) and Prugh (1986) came to similar conclusions that spontaneous remitters quit for the same reason that treated alcoholics do, and they use similar methods for maintaining their abstinence. This also closely follows the results of the current study in that the SR participants quit for very

similar reasons and used very similar methods (except of the use of AA and NA) for maintaining their abstinence.

For all seven SR's of this study, clarity was indeed a critical factor that has not been highlighted in previous studies. Even though SR's may quit for the same reasons as non SR's, this issue of clarity and following issue of a determined desire to recover are critical to SR's recovery and these characteristics set them apart from those who participate in AA or NA.

*Determined Desire to Recover.* All of the participants of the current study demonstrated an enormous desire to overcome their addiction. This generally manifested itself in a sense of mission for the participants. Several verbalized that their nature was to be goal oriented. Once they recognized a problem, it was just matter of solving it, they indicated.

This "determined desire to recover" parallels the description of Granfield & Cloud (1996) who stated that "Spontaneous remitters typically rejected the notion that they were powerless over their drug of choice; most saw themselves as capable and prided themselves on past accomplishments (p.52)." Also, according to Granfield & Cloud, spontaneous remitters viewed themselves as individualists and strong-willed. Other characteristics that represented the SR group in the current study included: rejecting powerlessness over their drug of choice and the characteristics of seeing themselves as capable, having pride over past accomplishments, being strong-willed and individualistic also.

*SR's Attitude Toward Addiction.* The SR participants of the current study varied in their attitudes toward the concept and label of addiction. This variance

ranged from having a strong “anti-addict” identity in one member of the SR group to more ambivalent views of the other SR group members. An “anti-addict” identity is the polar opposite of “addict” identity that is so much a part of the traditional treatment and the twelve-step movements of AA and NA. The acculturation process involved in AA and NA involves acceptance of the label of alcoholic or addict, thus members must adopt an “addict identity.” This “addict identity” is helpful in the recovery process of AA or NA by reminding the alcoholic or addict of their addiction, assisting them to not become complacent, and serves as a reminder that recovery from addiction is a life-long process. Two-thirds, of the participants of the Granfield & Cloud study “refused to identify themselves as presently addicted or as recovering or even recovered” (p.50). The participants in their study had adopted an “anti-addict” identity. In contrast, only one member of the current study expressed that sentiment with one other member expressing a very mild form of this sentiment. The other five members did not have any problem with the label or concept of being a recovering or recovered addict or alcoholic. Two SR members stated that they would have considered attending AA or NA if they thought that doing so would have been helpful. Also two different members of the SR group stated they would have benefited from treatment. This also contrasts considerably from the Granfield & Cloud findings. The participants of their study deliberately circumvented treatment and avoided twelve-step recovery meetings in large part due to their strong feelings concerning the labeling that occurs in those programs. The participants of the current study did seem to possess some ambivalence toward

both treatment and participation in AA or NA which contrasts greatly to the participants in the Granfield & Cloud study.

The participants of the current study did possess some of the “anti-addict” sentiment in that all of them were aware of AA or NA and they all did avoid these organizations. Also, all but two did not see any benefit to treatment. The reason for this may be related to the “stigma” they perceived of identifying with recovering drug addicts or alcoholics. Another reason that the participants of this study avoided AA or NA was that these participants did not see the relevance of AA or NA to them. This was most likely associated with their strong sense of independence and reliance on will power, self, and logic to overcome their addiction.

*Access to Support.* The SR group of the current study was resourceful in discovering the support they needed to assist in overcoming their addiction. Although this group relied heavily on their own motivation and will power, they also arranged for external supports: they changed jobs, found meaningful spiritual support, and relied on an informal support network of non-substance abusing friends.

Absent from this mix was the use of family as a predominate support. In contrast, the previous research of Granfield & Cloud (1996) suggested that family was a primary source of support for spontaneous remitters. This was not representative of the participants of this study. These participants instead needed and found multiple sources of support that were more consistent with their values and needs. If family was helpful, they used family, but, as is often

the case with drug addicts and alcoholics, families are fractured or not in a position to offer very much support.

There was an additional theme of the Granfield & Cloud (1996) study that contrasted greatly with the findings of the current study. This was the theme of stable background which will be briefly discussed.

*Stable Background.* The participants of the Granfield & Cloud (1996) study had a good education, career prospects, and family support. The participants of their study were from a stable, middle-class background and most of the 46 participants of that study were able use that background as support in the early phase of their recovery. This contrasts to the experience of the participants of the current study. Only two of the seven SR's here were able to use their background to support their recovery. Three of the seven participants literally had no background support to build on, and the remaining two had very limited background resources. Although the stable background of the middle-class may make spontaneous recovery more likely, the participants of the current study have shown a lack of background support was not an important factor. As discussed in chapter IV, members of the SR group did attain more education and in fact evolved into the middle class, but this occurred in their recovery. Only two of the seven initially had the support that comes from the middle-class that the participants of the Granfield & Cloud study possessed.

#### *Clinical Implications*

The findings from Chapter IV suggest three specific clinical implications. The first implication is that the Multimodal Process of Recovery (MPR) can be



used in working with addicted and recovering individuals. The second implication is recognizing that recovery may look different based on how an individual chooses to pursue that recovery. The third implication is that delivery of treatment may include “pre-treatment” interventions that can be accomplished in both a treatment and non-treatment environment.

*Implication One: Use of the Multimodal Process of Recovery*

This model has several practical applications. Individuals who are referred to treatment come with differing degrees of motivation and readiness. The MPR shows that for the initiation of recovery to occur, two deliberate actions must take place. The first action is the individual must respond to the external cues, that are indicating that his or her relationship with psychoactive substances is causing him or her a problem by seeking treatment or making a decision to cease the use of their drug of choice. But, there were varying degrees of motivation and readiness. The second action is an internalization for the desire to change. As previously discussed, internalization for the desire to change means coming to a clear understanding and motivation to change their life radically.

The clinical implication of this is understanding the needs of the referred individual. As an example, an individual who is referred to treatment by the judicial system could be “Acting on the Need for Change,” or, more likely, they are simply acting on the directive of the judge to avoid punishment. Treatment strategies would obviously be very different based on the very different needs of these two levels of motivation and readiness. For this example, the emphasis on the former, would be on assisting the individual to internalize their desire to

change and in the later, the focus would be on assisting the individual in understanding why change is necessary.

Treatment based on individualized needs (individualized treatment planning) is not new and was introduced as a component of the Minnesota Model of treatment in the late 1970's (McElrath, 1997). What is new is a *generalized framework that a treatment specialist can apply to individualized treatment planning*. By using the MPR, a clinician can assess where in the *Initiation or Adjustment Phase* the client is currently operating from and then make appropriate interventions. A focus of the treatment can then be on providing goals and associated tasks to make as much progress as possible in working through these phases and in avoiding relapse. The following is a brief example of the application of the MPR.

*Illustration of Using the MPR.* Due to a domestic violence conviction, both a husband and wife are referred from the local probation system to the community mental health and substance abuse services program for a substance abuse evaluation and treatment. Each individual is assessed individually using the Multimodal Process of Recovery (MPR). It is determined that the female spouse has tried on numerous occasions to stop using alcohol and has had some success, but often will relapse due to stress and negative affect. She states she is 100 percent sure that she is an alcoholic, but does not know what to do. Her husband, on the other hand, feels that his use of marijuana and alcohol are not a problem and suggests that he uses both substances recreationally and his life is better because of his use. These individuals are

represent a number of specific demographics, drugs of choice, and degree of addiction.

### *Suggestions for Future Research*

Based on the findings, analysis, and limitations of this study, the following recommendations for future research are indicated. These recommendations will assist in supplementing the relatively sparse literature on the recovery process concerning individuals who do not use the traditional methods of treatment and individuals who are treated traditionally but who do not use AA or NA.

#### *Recommendation One*

The first recommendation relates to individuals who typically are referred to as, AA or NA dropouts. What happens to these individuals? As was seen from the five participants of this study, they did very well. Is this the norm, or do these individuals have a more difficult recovery, or is their quality of recovery diminished due to non-participation in AA or NA? Therefore, a recommendation for further research is to attempt to answer those and other questions related to individuals who dropout of AA or NA.

#### *Recommendation Two*

A related recommendation is that researchers explore the influence that the Internet has had on the non-traditional recovery movement. This would include such non-traditional recovery movements such as Women for Sobriety (WFS), Secular Organization for Sobriety (SOS), and Rational Recovery (RR). These organizations were considered for locating participants for this study, but they were not needed because participants were located by other means. A

### ***Characteristics of Participants as a Limitation***

Another limitation lies in the characteristics of the participants themselves. As mentioned in Chapter III, participant selection was done via the snowball method. This method relies on selected participants referring other participants who also meet the criteria. With a sample size this small, it would be easy to get too much similarity and thus a restricted range of responses. However, the snowball technique employed for this study had five specifically different origination points. This provided a very heterogeneous sample, except for the fact that nearly half of the participants currently worked in or had worked in the addictions field or a closely-related field. This may have had an influence on the themes that emerged.

### ***Use of Semi-Structured Interviews as a Limitation***

Another limitation of this study is related to questions asked of the participants. Several questions could have been eliminated and several questions could have been reworded to correspond better with previous literature. For example, more questions concerning relapse would have been beneficial, as would have been a question eliciting more explanation concerning SRs' motivation for not seeking treatment. These questions may have yielded more consistent findings with the previous literature.

All of these limitations have solutions that will be discussed in the following section concerning suggestions for future research. Although the above limitations impact generalizability, the participants in this study did seem to

services (M.T. Phillips, personal communication, 2001). Another example is in the state of Arizona. In 1996 Arizona passed a ballot initiative by a wide margin that would mandate substance abuse treatment for most inmates in the their criminal justice system that are in need of these services. In Arizona, It is estimated that based on current treatment resource capability, only six percent of those in need will be able to receive any form of traditional treatment (Levin & Pinkerson, 1998). As the evidence of these examples show, the percentage of the addicted population that might benefit from a type of "pre-treatment" that fosters spontaneous recovery is potentially great and is worthy of investigating.

### *Limitations*

Several limitations to this study involving the methodology, selection of participants, and interview protocol are noted here. These limitations obviously must be considered when generalizing findings of this study to other samples of addicted populations.

#### *Methodology Limitations*

The type of qualitative methodology used for this study was in-depth interviewing of 17 participants. The number of participants involved with qualitative interviewing is often a much smaller number than with quantitative methodology. The question must be asked: if the number of participants had been increased three or four-fold would additional themes be generated? Also, if the number of participants in each group had been increased, would the differences between groups noted in Chapter IV have been different?

**individual sought assistance from her primary care physician (PCP), the PCP could assist her in understanding and accepting her addiction (fostering clarity), provide her encouragement in her desire to remain abstinent and most importantly refer her to an organization like Women for Sobriety or Secular Organization for Sobriety where she may find the support that she needs. This individual, based on her past experience and current life circumstance would not be a candidate for traditional treatment, but could do very well with limited interventions that would foster recovery based on her needs.**

**Interventions similar to the ones in the case example could be provided in virtually any setting. Obvious settings and type of practitioners would include, all levels of the criminal justice probation and case management system, outreach workers, community prevention and intervention workers, professional counselors, and even primary care physicians.**

**There is a segment of the addicted population who is not being served, either due to scarce treatment resources, or by choice who could still receive a form of treatment. An example of this, is evidence in one of the local municipal correction facilities. Based on a needs assessment of this facility, it was determined that approximately sixty-five percent of the inmate population of this correction facility is in need of substance abuse services (M.T.Phillips, personal communication, July 13, 2001). This is consistent with the literature on the relationship of criminality and substance abuse (Center on Addiction and Substance Abuse, 1998; Massaro & Pepper, 1994). However, based on scarce resources, only four percent of the population is receiving substance abuse**

**There are a number of categories of clients who potentially would benefit from intervention strategies that would foster spontaneous remission. These categories would include, many people in all levels of the criminal justice system, professional people who are concerned about their reputation or the time away from their responsibilities, and parents of dependent children who also are concerned about their reputation (and potentially losing their children) or time away from their family. Also, some individuals in the homeless community, who may not do well in or even have an opportunity to receive traditional treatment, would fall into this category. All of the above and many other sub-populations still could recover through interventions that fostered clarity about their addiction, assisted them in having a determined desire to overcome their addiction, and assisted them in locating access for adequate support.**

**The following case example shows how the fostering of spontaneous remission interventions could be accomplished. A mother of two school aged children who has a history of substance abuse problems knows that she is in jeopardy of losing her children. She has previously been treated for addiction and was able to keep her children because of her participation in treatment. She has resumed her alcohol use and knows that it is just a matter of time before she has another incident and loses her children. Because of stigma and her unconventional view of God, she feels that AA and traditional treatment would not be helpful. Also, being a single, working mother greatly limits her access to traditional treatment. With this example, this individual has some clarity of her addiction, a desire to overcome her addiction, but very little support. If this**

words of Vaillant (1983), it is very important that health-care professionals acknowledge, understand and utilize the natural healing process (spontaneous recovery). The participants of this study have helped to understand how this can be accomplished.

A primary motivation for spontaneous remitters to not seek treatment or participate in AA or NA seems to be the stigma that is related to addiction. For a segment of the population who needs treatment, stigmatization is a strongly held belief that will prevent them from seeking help or attending AA/NA. This was stated in both the previous literature (Granfield & Cloud, 1996) and by participants in the current study.

In addition to stigma related to addiction as a primary motivation for not seeking treatment or for not participating in AA or NA, the three key characteristics of the spontaneous remitters in the current study were, 1) the clarity that they had concerning their addiction, 2) the determined desire they had to overcome their addiction, and 3) their access to adequate support. These characteristics are somewhat consistent with the limited research concerning this topic (Granfield & Cloud, 1996). The clinical implication of these characteristics then, is for practitioners to use intervention strategies that considers the stigma, and that fosters the conditions of clarity concerning their addiction, a determined desire to overcome their addiction and, accessing adequate support in addicted clients who will reject or who do not have access to traditional treatment services.



examples from the participants of the current study illustrate this point. One client who, early in the treatment process, had both “Acted on the Need for Change,” and “Internalized a Desire for Change” objected to going to NA. This person felt that NA was contrary to his fundamentalist religious beliefs and felt that these beliefs could be served better within his religious community. He dutifully attended his prescribed NA meetings, but stated that the real change occurred for him in his church-related activities. He stated that the church-related activities were more relevant to him. An African-American female had similar feelings. She had grown up in the church and felt that the support she needed would come from there as opposed to AA, which consisted of a mostly white male population.

In summary, there is evidence that AA and NA have much to offer to many alcoholics and drug addicts, particularly, in early recovery, but it is important to understand that there are other methods to the same recovery goals. Clinicians need to consider these other means, in the context of their clients.

#### *Implication Three: Pre-treatment and Spontaneous Recovery*

There is mounting evidence, as discussed in Chapter II, that many and possibly most drug addicts and alcoholics spontaneously remit. Although there are no clear statistics as to the percentage of former drug addicts and alcoholics who spontaneously remit, the number is most likely large. What was clear from the current study is that this population does exist and they are not particularly difficult to locate. The implication of this is that there is much that the helping community can do to identify and encourage this process. To paraphrase the

**addition to assisting the client in assessing their natural healing assets and existing support system, the client and the clinician would consider various support options. In the current study, one participant dutifully attended AA meetings. He reported finding the meetings helpful, but thought that they were not a good match for him. Ninety days after treatment, he acted on this thought. He substituted the support he was getting from the meetings with that that he was getting from his family. This participant also felt that his goal-oriented, logical approach to life was not being reinforced in AA. Although he credits AA in reinforcing many helpful tenets of treatment, he was certain that, for his change process to be successful, he had to find another way that he could use his goal-oriented, logical approach. For him, the meaning of this was that, after he established a strong foothold in recovery, he could reassess his attributes of character that had been helpful in the past and apply those to the change process. In essence, this assessment of the attributes of character that had been helpful in the past and applying these to recovery is what the spontaneous remitters did. The spontaneous remitters were able to clearly see what the problem was (addiction), and they applied the attributes of their personality that they thought would be helpful, and they utilized the helpful supports that existed in their environment.**

**Toward this important end of helping the client to discover his or her attributes of personality and helpful supports that exist in their environment, clinicians must be aware that often what AA or NA has to offer lies in direct conflict with important helping resources that are more natural to the client. Two**

**all individuals. Just as the clinician must decide what the needs of the client are in order to develop an individualized treatment plan, the clinician also must decide on the best way (method of recovery) for the client to meet her or his needs.**

**The participants of this study demonstrated that a radical change could occur in a variety of ways. Each client brings with him or her different types and levels of external support and different internal approaches to the change process. The most vivid example of this lies in how each of the participants of the TX group found that their needs were not being met in AA or NA. As a result, they had to find other methods of support. Clinicians must learn that the recovery needs of their clients may very well be met in a variety of ways.**

**The participants of this study were able to find healing processes that were consistent with their personalities and worldview. The previous literature does not address this issue and, yet, it is an issue that is central to the findings of this study. Because of the diverse way that this study shows that the participants were able to facilitate their recovery, a role of the treatment provider could very well be to assist clients to learn what these processes are, and to match these processes with several different recovery options.**

**Consistent with this implication of understanding different methods of recovery, another role of treatment based on this research, would be to assist the client in better understanding what natural supports the client has in his or her environment and how to best utilize these supports. This study, as well as previous studies, reveals the importance of support in the change process. In**

obviously at very different places in the change process and need very different interventions. Using the MPR, the clinician can develop effective goals and treatment strategies for each individual based on the needs of the assessed phase. For example, stress management and relapse prevention strategies would be indicated for the woman in this case, but these strategies would not be effective for the man until he had accomplished the tasks of "Acting on the Need for Change," and "Internalizing a Desire for Change."

*Implication Two: The Different Methods of Recovery*

Using the MPR to assist in developing individualized treatment is important, but so is understanding that different individuals, based on their worldviews and different aspects of personality, may pursue recovery in different ways. Understanding this will also be beneficial for clinicians in providing recovery interventions that are helpful to their clients.

This study implies that successful, long-term recovery can be facilitated in three different ways. These ways include, the traditional use of treatment and AA or NA to support their recovery (the AA group); the use of treatment followed by internal and external supports other than AA or NA (the TX group); and, spontaneous recovery that does not use treatment or AA or NA to support their recovery (the SR group). The personality transformation achieved by the participants in the AA, TX, and SR groups of this study showed that the same results could be achieved in the three distinct ways that defined their groups. The implication that long-term recovery can be facilitated in different ways for treatment, indicates that a single method of recovery, most likely will not work for

comparison of individuals who use these programs for recovery with the participants of this study or more traditional methods would be helpful in understanding the differences or similarities of recovery by these means as compared to the participants of this study.

*Recommendation Three*

Another recommendation for research would be to use the results of this study to develop a questionnaire and subsequently conduct a descriptive study of the recovery process that involves a more inclusive sample of the recovering population. The results of the descriptive study, in concert with this qualitative study, should provide the basis for development of a quantitative research design that focuses on relationships or causality.

*Recommendation Four*

A recommendation concerning the interview protocol would be to rework the interview instrument, based on the outcomes of this study and other similar research such as Kubicek (1998) and Russell (1987). More precise follow-up questions could clarify the meanings of the participants, and using what was gained and refining the questions should yield additional valuable information.

*Recommendation Five*

A final recommendation would be to conduct more study of the characteristics of spontaneous remission using a sample that is designed to capture a wide range of demographics and personality characteristics. The question that needs to be asked relates to the relationship between spontaneous recovery and cognitive development, education, or socio-economic level. The

current study suggested that cognitive development may be a factor in the successful spontaneous recovery process. The participants from the SR group placed more value on education, tended to be more goal oriented, and used logic more than members of the TX or AA groups. These factors as well as their success at spontaneous recovery may have been influenced by their cognitive development.

### *Conclusion*

Recovery from alcoholism and drug addiction can and does occur. This study revealed a model of recovery that is not dependent on a single recovery method. Participants of this study were individuals who were treated for addiction and pursued their recovery with the assistance of AA or NA, who were treated for their addiction but rejected AA or NA, and who were not treated for their addiction and who did not use AA or NA to support their recovery. All had many years of recovery (5 – 19 years), were doing extremely well in recovery, and, indeed had experienced a personality transformation as compared to their addicted self.

Although there were some differences in how recovery manifested based on method of recovery, a common model of the process of recovery emerged. This model consisted of four phases and eleven themes that included accepting one's addiction by "Acting on the Need for Change," and "Internalizing a Desire for Change," adjusting to sobriety by "Learning to Deal with Stress and Change," and "Learning to Live a Sober Life," and continuing the growth and personality transformation initiated by cessation of the use of psychoactive substances. This

**model also identified a relapse component. Relapse occurred for nearly half of the participants of this study and is a common phenomenon. This model, termed the Multimodal Model of Recovery (MMR) because of its use of three distinct modes for accessing recovery, can be used by practitioners as a framework for working with chemically dependent clients.**

**This study also suggested that, with a minimal amount of intervention, many addicted individuals can be motivated to “spontaneously remit.” Motivation to spontaneously remit can be accomplished by various health-care and other professionals encouraging the factors of spontaneous remission exhibited by the participants of this study. These characteristics included, clarity concerning one’s addiction, a determined desire to overcome addiction, and identification of helpful supports that exist within one’s environment.**

**With 12-19 million people who reside in the United States addicted to psychoactive substances and an estimated only ten percent ever receiving formal treatment (Fletcher, 2001; Miller, Swift, & Gold, 1998), the use of these minimal interventions to facilitate spontaneous remission may prove to be helpful. These interventions can be used by service providers who do not normally provide substance services and greatly impact the number of individuals who need, but who do not normally receive treatment.**

**The results of this study suggest a general way of viewing and attending to the addiction problem in this country. However, these implications should not be viewed as a panacea. The implications of this study highlight the importance of understanding that multiple factors are involved in the recovery process and**

**that that these factors can be facilitated in different methods of recovery. Using a general process of recovery in concert with understanding the different methods of recovery, including spontaneous remission, should be helpful in addressing the addiction problem.**



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**APPENDIX A**  
**SOLICITATION LETTER**

**Assistance Needed**

**Research Study On  
Long-term Recovering Substance Abusers**

I am currently conducting a research study on long-term recovering substance abusers. I am in need of research participants who have had a problem with alcohol or other drugs and who currently have five years of continuous abstinence.

This study is to complete my requirements for a doctoral degree from Old Dominion University.

I am particularly looking to interview individuals who

- 1) Have **never** received professional treatment for their substance abuse problem and who never attended (or attended for a short time) Alcoholics Anonymous (AA) or Narcotic Anonymous (NA),

and I am looking for individuals who,

- 2) were professionally treated for their addiction and did not attend Alcoholics Anonymous or Narcotic Anonymous after their first year or two of recovery.

The interview should take between one and two hours.

All information about the participant will be kept confidential.

Please contact the researcher if you are interested in participating in the research project:

Mark T. Blagen  
Home Phone 757-496-3315  
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## **APPENDIX B**

### **Informed Consent Document**

for  
Old Dominion University

#### **Informed Consent Document**

The purpose of this form is to give you information that may affect your decision whether to say yes or no to participation in this research, and to record the consent of those who say yes.

**Title of Research:** "A Naturalistic Inquiry into the Processes and Themes of Recovery from Addiction."

**Researchers:** Mark T. Blagen, MS. Ed., College of Education, Education Leadership and Counseling

#### **Description of Research Study:**

The purpose of this study is to identify how long-term recovering drug addicts and alcoholics understand their success. Current research about this topic is lacking and this study hopes to gain a better understanding of this group of people.

If you decide to participate, your participation will involve an interview of one to two hours in duration that will be audio-taped, unless you request that it not be taped. This interview will involve being asked 20 questions that relate to your recovery from addiction. Later you will be given a copy of your interview and the interpretation of your response. At that time, you will be asked to comment and have the opportunity to respond in writing or by phone with your reactions to the results of the interview and the validity of the interpretation.

#### **Exclusionary Criteria:**

You should have completed a short screening form. To the best of your knowledge, you should not have any untreated anxiety or depressive disorders that would keep you from participating in this study.

#### **Risks and Benefits:**

**Risks:** The possible risks to you if you participate in the study are similar to those that come with increased awareness. You understand that if side effects or discomforts do occur, Mark Blagen will minimize and treat these by offering to discontinue the interview or by supportive debriefing.

Because you are sharing information that is private and may be embarrassing or could potentially be used to discredit you, harm could occur through disclosure.

This can be compared with you sharing some incident from your past with an individual who divulges that information to another. The likelihood that your identity will be divulged or discovered is unlikely. Throughout the study, you will be referred to by participant number only. Brief quotes from you may be used in the dissertation, but again, only participant number will be used. Any information matching participant number to your full name will be maintained by myself in a secure place known only by myself. All field notes, transcripts, and tapes will remain in the possession of the researcher, will be secured at all times, and destroyed after three years.

**Benefit:** The specific benefit to you of this study is that you may better understand your recovery process. Another benefit of your participation in the research study is that the field of alcoholism treatment may gain a better understanding of how people like yourself can successfully recover from addiction. This understanding could lead to more research that would identify treatment interventions to improve successful recovery rates.

**Costs and Payments:**

The researchers want your decision about participating in this study to be absolutely voluntary and understand that your participation may pose some inconvenience such as loss of time. The researchers are unable to give you payment for participating in this study.

**New Information:**

If the researcher finds new information during this study that would reasonably change your decision about participating, they that information will be given to you promptly.

**Confidentiality:**

The researcher will take reasonable steps to keep all private information obtained from the screening form and the interview confidential. The researcher will refer to participants by number only and the link of the number to the participant will be kept in a secure place. All tapes and transcripts will be kept secure and will be identified by number only. You understand that the results of the research study may be published but that names or identities will not be revealed and that your transcript will remain anonymous and out of the public domain. Any quotations or other descriptive data that is published will be identified by number only.

**Withdrawal Privilege:**

You understand your participation is voluntary and that refusal to participate will involve no penalty to you or loss of any benefits to which you are otherwise entitled. You understand that you may withdraw from the research study at any time without penalty or prejudice.

**Compensation for Illness and Injury:**

If you say yes, then your consent in this document does not waive any of your rights. However, in the event of harm, injury, illness arising from this study, neither Old Dominion University nor the researcher are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Dr. Garrett McAuliffe at 683-3221 or Dr. David Swain at 683-6028 at Old Dominion University, who will be glad to review the matter with you.

**Voluntary Consent:**

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand the form, the research study, and its risks and benefits. The researcher should have answered any questions you may have had about the research. If you have any questions later on, then the researcher, Mark Blagen who can be reached at 757-496-3315 or e-mail [mblagen@odu.edu](mailto:mblagen@odu.edu), should be able to answer them.

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call Dr. David Swain, at 757-683-6028, or the Old Dominion University Office of Research, at 757-683-3460.

And importantly, by signing below, you are telling the researcher yes, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Consent Signature of Participant

\_\_\_\_\_  
Printed Name of Participant

**Investigator's Statement:**

I certify that I have explained to the above participant the nature and purpose of this research, including benefits, risks and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the participant's questions and have encouraged him or her to ask questions at any time during the course of this study. I have witnessed the above signature on this consent form.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Researcher



**APPENDIX C**  
**Participant Screening Form**

Name: \_\_\_\_\_

Contact phone #: \_\_\_\_\_

What was your drug(s) of choice \_\_\_\_\_

Have you ever been diagnosed as Substance Dependent  
\_\_\_\_\_

If no, briefly explain why you feel that you were once substance dependent:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of years of continuous sobriety \_\_\_\_\_

Have you attended Alcoholics or Narcotics Anonymous meetings \_\_\_\_\_

Have you attended Alcoholics or Narcotics Anonymous meetings after first year  
of recovery \_\_\_\_\_

What is your approximate frequency of attendance of Alcoholics or Narcotics  
Anonymous meetings \_\_\_\_\_ per \_\_\_\_\_

Were you ever been professionally treated for chemical dependency?  
\_\_\_\_\_

What kind of professional treatment did you receive?: \_\_\_\_\_

Are you currently experiencing any anxiety or depressive mood disorders that  
are not being treated? Yes \_\_\_\_\_ No \_\_\_\_\_

## **VITA**

### **Mark Thomas Blagen**

#### ***Biographical and Educational Background***

I was born in McCook, Nebraska and raised in Denver, Colorado with frequent visits to family in western Nebraska. I Attended public school and enlisted in the U.S. Navy after graduation from high school. While serving in the U.S. Navy for 21 years, I accumulated 184 semester hours of undergraduate work from nine different colleges and universities. While on active duty, I was granted a Bachelor of Science from the University of the State of New York with a major in Sociology with a conferral date of September of 1988. Also while on active duty, I completed a Masters of Science in Education in Counseling from Old Dominion University with a conferral date of December of 1990 and began work on this degree.

#### ***Counseling Experience***

I have been a Certified Addictions Counselor (CAC) since 1990 and have worked in various addictions treatment and prevention settings including residential inpatient, outpatient and in the public schools co-developing, coordinating and implementing a Student Assistance Program.

#### ***Department Address***

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