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"I OWE MY RECOVERY TO THE GROUP"

HOW ADDICTS LEARN TO RECOVER:

A CASE STUDY OF AN ADDICTION AFTERCARE GROUP

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Submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

in the School of Education, College of Humanities,

University of KwaZulu-Natal

SUPERVISOR: PROFESSOR WAYNE HUGO

November 2019

SUPERVISOR'S PERMISSION TO SUBMIT

I, Wayne Hugo, as the candidate's supervisor, agree / do not agree to the submission of this thesis.

_____ _____

Supervisor's signature Date

ABSTRACT

This study explores how addicts learned to recover in an addiction aftercare group by identifying the pedagogic and group mechanisms of recovery, and revealing the knowledge and competencies that assisted participants. Part One outlines the ongoing, critical problem of addiction, both internationally and locally, and group approaches to recovery. Part Two analyses the findings, locating each category of findings in its own literature review.

The interdisciplinary study was informed by communities of practice theory (1991, 1998) and elements of attachment-based psychology theory, focusing on identity. Psychological challenges for the addicted population were highlighted and linked to Khantzian's self-medication hypothesis (1975) and to research on the attachment aspect of groups. This work provided conceptual tools that broadened understanding of the aetiology of addiction being formed by, and redressed through, relationship.

Research on two relevant group models - the psychological approach and the twelve-step model - was used to guide the approach to the case study.

Case study and bricolage methodologies were employed in the qualitative study. The nineteen participants were from a clinic addiction aftercare group in a city in KwaZulu-Natal, South Africa. Each had achieved over a year of unbroken recovery. The group was co-facilitated by three consecutive addiction counsellors and the author. Data was collected from eight individual interviews and five focus groups. The emergent themes were analysed using a hybrid method of thematic analysis and interpretive phenomenological analysis.

The findings revealed that group recovery transformed key aspects of the person with addiction: spiritual and religious; psychological (including emotional regulation — specifically of shame, anger and honesty, working with empathy and the development of self-esteem); and physical. These were termed 'Mechanisms of Transformation'.

Mechanisms that emerged as critical to addiction group recovery were Mechanisms of Transformation; Membership; Regime of Competence; and the Competency Framework. Membership is crucial as it overcomes the alienating aspects of shame and creates

opportunity for acceptance, belonging and participation. The Regime of Competence — the authority aspect of the group — allows participants to call errant members to order on key issues such as honesty. This is essential as relapse begins in thought and other behaviour and can be identified in transgressions of the Regime of Competence. The Competency Framework is an evolving repertoire of essential recovery skills and knowledge. From these mechanisms, I developed an interactional model that suggests how the mechanisms work as components of the recovery practice and highlights their possible effects on participants' recoveries.

This model could prove beneficial to addiction recovery groups in varied contexts. Limitations are that a single case was used in a particular context, making generalisation tentative until followed up empirically. This study makes a methodological contribution in terms of 'insider' research. It also makes an interdisciplinary contribution to the advancement of knowledge in terms of the understanding of group recovery from addiction, particularly in South Africa.

DECLARATION

I, Margot Jane Sennett Freedman, declare that

1. The research reported in this thesis, except where otherwise indicated, is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
4. This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
    a. Their words have been re-written, but the general information attributed to them has been referenced
    b. Where their exact words have been used, then their writing has been placed inside quotation marks, and referenced.
    c. Italics have been used for the participants' words.
5. This thesis does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the thesis and in the References sections.

Margot Jane Sennett Freedman
22 November 2019
Supervisor: Prof. Wayne Hugo

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- The management of the clinic which housed the addiction aftercare group and where the data was largely collected.
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As with many families, education has opened the door to a better life for ours. I wish that you all use these opportunities to bring out your gifts and make a difference to the world.

Jess and Em, I dedicate this to you.

ETHICAL CLEARANCE CERTIFICATION

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

11 February 2015

Ms Margot Jane Sennett Freedman (214583276)
School of Education
Pietermaritzburg Campus

Dear Ms Freedman

Protocol reference number: HSS/1230/014D
Project title: How do addicts learn to recover? A case study of an Addiction Aftercare Group

Full Approval Notification – Committee Reviewed Protocol

This letter serves to notify you that your response received on 16 January 2015 to our letter of 12 November 2014 in connection with the above was reviewed by the Humanities & Social Sciences Research Ethics Committee, has now been granted **Full Approval.**

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study.

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Professor Wayne Hugo
Cc Academic Leader Research: Professor P Morojele
Cc School Administrator: Ms Bongi Bhengu

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UNIVERSITY OF KWAZULU-NATAL
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05 December 2017

Ms Margot Sennett Freedman 214583276
School of Education
Pietermaritzburg Campus

Dear Ms Freedman

Protocol reference number: HSS/1230/014D
Project title: How do addicts learn to recover? A case study of an Addiction aftercare group.

Full approval – Recertification

Your request for Recertification dated 04 December 2017 was received.

This letter confirms that you have been granted Recertification Approval for a period of one year from the date of this letter: This approval is based strictly on the research protocol submitted in 2014.

Any alteration s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through the amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study.

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully

Naidoo

Dr Shamila Naidoo (Deputy Chair)

/px

cc Supervisor: Professor W Hugo
cc Academic Leader Research: Dr SB Khoza
cc Administrators: Ms T Khumalo and Ms P Ncayiyana

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UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

28 November 2018

Ms Margot Sennett Freedman 214583276
School of Education
Pietermaritzburg Campus

Protocol reference number: HSS/1230/014D
New project title: I owe my recovery to the group – How addicts learn to recover: a case study of an addiction aftercare group.

Approval – Recertification

In response to your application dated 02 November 2018, the Humanities and Social Sciences Research Ethics Committee has considered the above mentioned application and the protocol has been approved for one year from the date of this letter. This approval is based strictly on the research protocol submitted in 2014.

Any alteration s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through the amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. Please note: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully

.....
Prof S Singh

/PX

cc Supervisor: Prof W Hugo
cc Academic Leader Research: Dr SB Khoza
cc Administrators: Ms S Jeenarain, Ms M Ngcobo and Mr SN Mthembu

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DISSEMINATION

Publications

Freedman, M. J. S. (2018). Coming clean about substance use disorder: Factors affecting treatment-seeking and compliance, and strategies to overcome them. *Occupational Health Southern Africa, 24*(1), 4–8.

Professional Workshop

13 April 2017: *Demystifying substance use disorders — Some considerations for student counsellors: Factors affecting treatment-seeking and compliance, and strategies to overcome them*. Presented to psychologists in Student Support Services in the College of Science, Agriculture and Engineering and the College of Law and Management, UKZN.

26 May 2017: *Demystifying substance use disorders — Some considerations for student counsellors: Factors affecting treatment-seeking and compliance, and strategies to overcome them*. Presented to psychologists and intern psychologists in Student Support Services in the College of Humanities, UKZN.

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AA	Alcoholics Anonymous
AOD	Alcohol and other drugs
APA	American Psychiatric Association
CDA	Central Drug Authority
CIDI	Composite International Diagnostic Interview
CSAT	U.S. Department of Health and Human Services Center for Substance Abuse Treatment
DALY	Disability-adjusted life year
FAS	Foetal alcohol syndrome
IPA	Interpretative phenomenological analysis
IPV	Intimate partner violence
IRL	Institute for Research on Learning
LPP	Legitimate peripheral participation
NA	Narcotics Anonymous
SACENDU	South African Community Epidemiology Network on Drug Use
SADAB	South African Drug Advisory Board
SADHS	South African Demographic and Health Survey
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMRC	South African Medical Research Council
SAPS	South African Police Services
SASH	South African Stress and Health Survey
SMH	Self-medication hypothesis
SUD	Substance use disorder
TSF	Twelve-step facilitation
U.S.	United States
USSAMHS	U.S. Substance Abuse and Mental Health Services Administration
OSG	Office of the Surgeon General
YRBS	Youth Risk Behaviour Survey

CHAPTER 1
INTRODUCTION

1.1 MOTIVATION FOR THE STUDY

"I owe my recovery to the group."

As a psychologist of thirty years standing, I have heard recovering addicts make this claim countless times in the context of the recovery groups I have facilitated. Having watched many attempt the journey of recovery, I have witnessed how difficult it is to achieve and sustain the personal transformation that is necessary for lasting recovery, and how those committed to the path overcome their addiction.

While sitting in a group, I was often aware of how keenly interested the participants were in each other's experiences of recovery. When a member shared something which resonated deeply with the other members, the atmosphere changed subtly in the room: a spellbound silence would fall, the eyes of the others would widen as they leaned forward into the tale, mulling over each word; I could watch the connection and bond between the members deepening through the sharing and receiving of something that was touching and deeply valued.

I could see that something happened in this process which enabled a member to recover from addiction through a process of individual transformation — a secular transubstantiation of sorts, where words communicate feelings and experiences, which communicate insights and meanings, which resonate with the listener and penetrate deeply, providing the fertile ground, new tools and nourishment for the personal change begun during their rehabilitation to root deeply and grow.

Despite having watched this process occur countless times, the actual mechanisms occurring in the group context which facilitated this transformation remained elusive to me. What exactly was it about the group that enabled people who were in extremis — having lost almost everything in terms of money, work, good relationships and health — through regular attendance and participation in a group to attain a long-term abstinent, healthy, responsible and meaningful way of life? What was it about a group that could facilitate and sustain such profound transformation within its participants?

Globally, there is a critical need for recovery models which achieve long-term recovery from addiction. The drug and alcohol problem worldwide has reached crisis proportions. More United States citizens died of opiate overdose in 2016 (62 497) than during the entire duration of the Vietnam War (58 200) (Lopez, 2017). In a study conducted in South Africa between 2002 and 2004, it was found that 13.3% of adult South Africans had met the criteria for a substance use disorder diagnosis at some time in their lives (van Heerden et al., 2009). That was 15 years ago; more recent statistics reveal a rise in adolescent substance abuse in South Africa (Ramsoomar & Morojele, 2012). The SA National Youth Risk Behaviour Survey (YRBS) found that 15% of pupils admitted to using over-the-counter drugs to get high (Peltzer et al., 2010). Almost 9% of the students had tried methamphetamine at least once, while 3% or less had tried Mandrax (methaqualone) (Pluddemann et al., 2010). According to the United Nations Office on Drugs and Crime, South Africa is a regional hub for drug trafficking (Fedotov, 2016). An increase in the prevalence rates of illicit drug use was observed from 2008 to 2012 in South Africa (Peltzer & Phaswana-Mafuya, 2018). Addiction is also — particularly in South Africa — linked to violent crime (Parry et al., 2004).

Surprisingly little research has been done on mechanisms of recovery from addiction; however, the studies that have been done have shown that participation in a supportive recovery group is key to sustained recovery (Bliuc et al., 2019). No research, however, has yet studied the mechanisms within the group which facilitate the learning that transforms the addict, enabling her to sustain her recovery. The task I set myself with this study, was to fill this gap by uncovering the mechanisms operating within the group dynamics to reveal the elements responsible for individual transformation in the journey from addiction to long-term recovery.

1.2 RATIONALE: AIMS, QUESTIONS AND APPROACH OF THIS STUDY

The rationale of this study was to make a specific contribution to addiction recovery by conceptualising key knowledge and practices used in addiction-related group work. This study also sought to contribute to the understanding of group work as a key intervention in recovery maintenance in the context of South Africa, specifically, as it is more

affordable and accessible than individual counselling and is congruent with the values upheld in African culture (particularly *ubuntu*).

The aim of this study was to discover how participants in the addiction recovery group learn to recover, specifically:

1. to identify what in, or about, the group assists regular participants maintain their recovery;
2. to identify and explore the teaching and learning processes which take place in the addiction recovery group; and
3. to discover what knowledge helps participants maintain their recoveries.

The primary research question this study investigated was:

> How do regular participants in the addiction recovery group learn to recover?

This question was investigated through three sub-questions:

1. What in, or about, the group assists regular participants to sustain their recoveries?
2. What pedagogic mechanisms are used in the group?
3. What knowledge helps participants sustain their recoveries and what knowledge is useful to them in the maintenance of recovery?

With the help of my supervisor, Prof. Wayne Hugo, I conceptualised the study as the pursuit of understanding a single phenomenon. This relieved me of the need to "unweave a rainbow," in the words of Keats in Part II of *Lamia*, which he wrote in 1820 (Keats, 2017). Instead, I could pursue an understanding of this phenomenon with the same sense of reverence with which I had experienced it in the group. I was determined to preserve the palpable sense of awe which had motivated the study throughout its execution — while rigorously doing justice to the research.

The study took an interdisciplinary approach, drawing on the traditions of both psychology and education to enable a greater purchase of the phenomenon. Although my background is in psychology, I chose to locate my PhD within the School of Education because, although addiction may be a disease, I did not want to apply a pathological lens to the phenomenon which was the subject of this study. As the (homemade) dictum goes,

"psychology is about making a person better; education is about making a better person". Under the guidance of my supervisor, the field of education offered an alternative way of examining the mechanisms of addiction group recovery by using the lens of social learning theory — specifically communities of practice, with its emphasis on identity transformation within a practice — while also being able to apply and integrate many understandings from psychology.

The study used a qualitative research approach in order to provide a rich and detailed account. It was located within an interpretive paradigm, focusing on meaning — thus giving fullness to the human experience. It examined aspects of recovery from substance addiction in a group context through a pedagogic lens, making use of bricolage, thematic analysis and case study methodology.

1.3 OVERVIEW OF THE THESIS

This document consists of two main parts: the historical, theoretical and methodological background to the study (Part One), and the presentation and analysis of the findings of the study (Part Two).

Part One contextualises this study within the landscapes of addiction and recovery globally and in South Africa (Chapter 2) and mutual-aid and therapeutic group work as effective models in recovery (Chapter 3). It grounds the study in theories of social learning (particularly communities of practice) and psychoanalytic understandings of addiction (especially Khantzian's self-medication hypothesis) (Chapter 4). This part of the study concludes with a presentation of the research design and methodology (Chapter 5).

Part Two presents findings to the research questions which are analysed thematically in terms of their role in the spiritual (Chapter 6), psychological (Chapters 7–11) and physical (Chapter 12) aspects of participants' personal transformation in the context of the recovery group. Chapters 6 to 12 answer the first two questions. The third question is answered by Chapter 13, which moves away from a close engagement with the participants' experience and takes a meta-stance on the data, which involves a change in tone and approach. It is based largely on focus group data, whereas the first two questions are mostly answered by data from individual interviews. Chapter 13 applies key concepts from communities of practice theory to deepen the concept of knowledge developed in

this study and situate the phenomenon more deeply in theory. The conclusion brings the findings together, illustrating the contribution of this study to pedagogic approaches on addiction recovery and practice.

1.4 CONTRIBUTIONS OF THE STUDY

As this is a single case study, any generalisation of these findings must be made with careful consideration for context. As the first study on the topic of group mechanisms in recovery from addiction, however, it contributes new knowledge which may be applicable to many recovery contexts. As an interdisciplinary study, this thesis provides a deep and integrated account of group mechanisms that play an essential role in individual transformation and long-term recovery from addiction. My positionality as both therapist and researcher in the context of the recovery group that was the focus of this study, while having both advantages and disadvantages, yielded data of a higher quality than might have been expected otherwise. This study thus contributes to the fields of psychology, education and addiction, to the methodology of insider research and positionality, and to group work in recovery, both in South Africa and globally.

PART ONE: CONTEXT OF THE STUDY

CHAPTER 2
BACKGROUND TO THE PHENOMENA OF ADDICTION AND RECOVERY

2.1 INTRODUCTION

This is the first of two background chapters contextualising the recovery group that is the focus of this study. This chapter explores the global problem of addiction and the process of recovery, looking at how these two phenomena have been understood and how treatment and recovery as a response to addiction have evolved in the literature and within the logistics of the South African context, where recovery resources are limited. Recovery is understood to be a lifelong process of maintaining well-being to protect against the risk of relapse; a better understanding of the barriers to successful recovery and the factors in the recovery process which best promote long-term recovery is therefore needed (Laudet, 2013). This study addresses this existing gap in the research on recovery by exploring the role of regular participation in a recovery group in the success of individuals in maintaining their recovery, and by investigating, specifically, the nature of the transformation experienced by members of the group and the mechanisms that helped participants to sustain their recoveries.

2.2 KEY TERMS

Because addiction is considered a disorder of the whole person, the problem is considered to exist at the level of the person and not the substance. An addict can cross-addict from one substance to another; addiction is thus only a symptom and not the essence of the disorder (Denisco et al., 2008; Katz, 2015). As the focus of this study was on the person and his or her experience with recovery in an addiction support group, diagnosis referring to substance was not particularly helpful in this context.

For this reason, the term ‘addict’ is used in this study, as it focuses on understanding the person of the addict rather than on categorising individuals on the basis of the substances to which they are addicted. The use of the term ‘addict’ **is not intended to be derogatory**. When participants were asked how they would like to be referred to in this study, they

unanimously chose ‘addict’ (over options such as ‘person with addiction’ or ‘person with substance use/abuse disorder’). Participants frequently used the term ‘addict’ to refer to themselves — claiming the term in a similar and empowering way to the way queer theory claims ‘queer’.

Secondly, the term ‘substance’ is used throughout to refer to all potentially intoxicating substances of abuse, except in a case where another term is used in a direct quote from a study participant. Addictive behaviours such as sex addiction and gambling are also inferred by this term.

Finally, where research has focused on specific addict groupings or substances — such as alcohol in the case of Alcoholics Anonymous (AA), for example — the findings have been reported as such.

2.3 UNDERSTANDING ADDICTION

In the early 1940s Morton Jellinek, one of the early pioneers in the field of addiction who had worked with alcoholics, demonstrated that there were clearly defined destructive and progressive changes in the behavioural patterns of alcoholics as they continued to drink over time (Jellinek, 1946, 1952). He was the first person to document that alcoholics’ problems worsened on a curve over time. He created a comprehensive overview of the prognosis showing the compulsive, destructive nature of addiction; the Jellinek Curve is used globally to describe all kinds of addictions. It is interesting to note that the curve reflects that both group therapy and mutual aid were considered key to the recovery process from at least the 1940s onwards. The curve also captures the reality that addiction is highly destructive, not only to those who are addicted but also to those close to them. One criticism of this model is that the curve does not accurately describe the path of recovery, which for most addicts consists of relapses. However, it is useful as a general depiction of the gradual destruction that occurs with addiction followed by the recovery process.

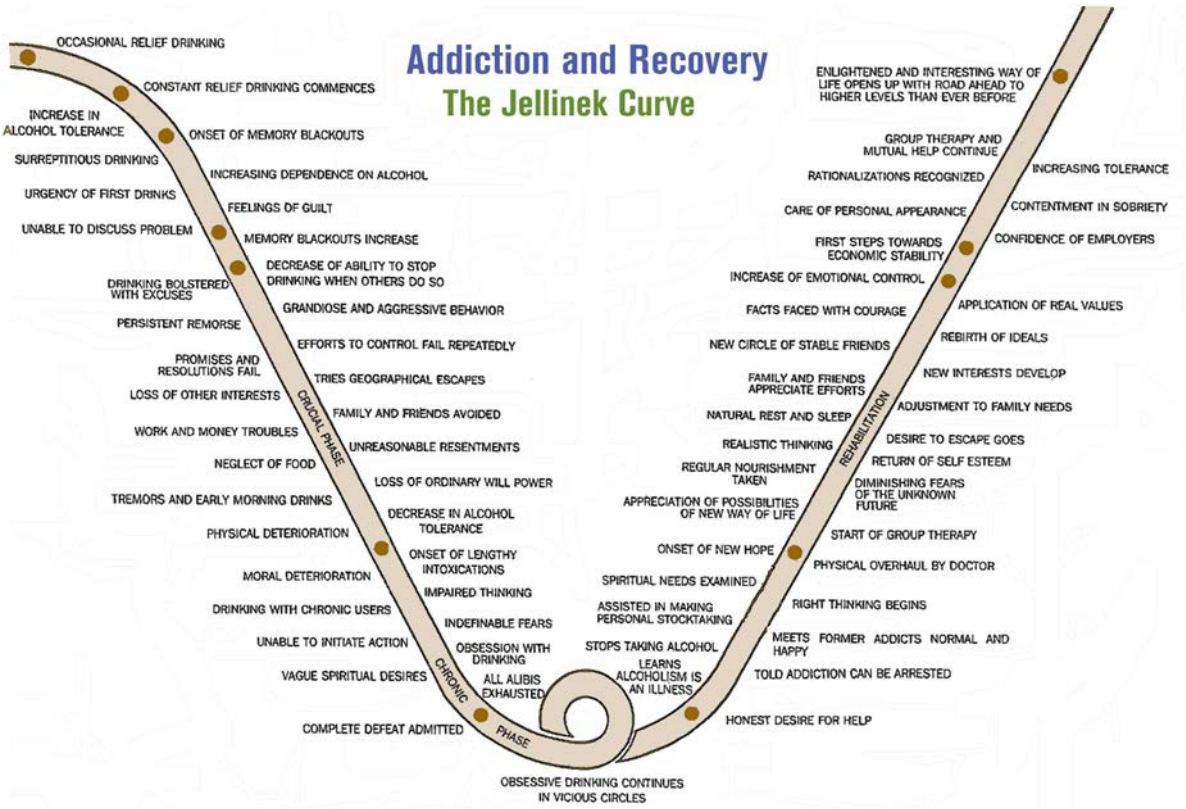


Figure 2.1 The Jellinek Curve describing the path of addiction and recovery (Jellinek, 1946)

Addiction has been termed by AA a "chronic disease that is 'cunning, baffling and powerful'" (Alcoholics Anonymous [AA], 2001, pp. 58–59). It is arguably one of the most destructive, complex and misunderstood conditions of the human being. Part of what is so confusing about addiction is how someone can deliberately engage in behaviours that are so clearly and increasingly destructive to him or her. Both the general public and medical practitioners often do not fully understand how addiction works and believe that addiction is an acute condition that can be resolved by treatment at a rehabilitation centre. This means that when the addict relapses after leaving rehab, as most do, they consider the treatment to have failed to resolve the addiction.

Addiction is, in fact, a chronic condition which is not resolved by merely denying the person access to the substance, or by the person going through physical withdrawal from the substance (O'Brien & Thomas McLellan, 1996). Abstinence — no longer using the substance — is only the first part of recovery. The harder part is 'staying stopped': the

addict actually living out the commitment to recovery on a daily basis. This is examined later in this chapter and in subsequent chapters. 'Staying stopped' and the mechanisms that exist in support groups to enable an addict to sustain this are the focus of the study.

The complex phenomenon of addiction has been researched extensively across a range of disciplines, including medicine, brain science, psychology and criminal justice (Kemp, 2011). Recent research in the field of brain science and epigenetics has demonstrated that the immediacy of reward associated with drug use is associated with measurable changes in brain chemistry (Gross, 2013). Epigenetic studies have found that permanent changes occur in the addict's brain during active use of a substance, which may still be evident years after the person has stopped using the substance (Eisenberg, 1996). This means that the addict is cued to those substances and primed, even though abstinent for years, to contexts that will deliver the brain reward (pleasurable feelings which reinforce addictive behaviour) (Stewart, 2008). This is one of the reasons that the addicts in this study preferred to be called addicts: they understood that they needed to avoid addictive substances for the rest of their lives, regardless of how many years they may have been abstinent.

From a neurobiological point of view, the prefrontal cortex plays a key role in executive function, which allows the individual to plan and execute goal-directed behaviours. The addict's brain experiences the payoff for using the substance as a greater reward than anything else that they might get and focuses increasingly exclusively on obtaining the brain reward payoff from their substance. This is why addiction is so powerful and recovery is such a massive challenge and, when it takes place, such a victory. From a neurobiological point of view, then, the work of recovery lies in strengthening the function of the prefrontal cortex to perform optimally in the service of health and wellness for the addict. Key aspects of the work of recovery are, therefore, for the addict to learn that denial is part of the disease and is the mechanism by which it perpetuates itself, and to learn how to recognise it, how to control impulsivity and improve decision-making, and how to understand and manage cravings and respond in healthy ways to them.

In an analysis of 52 studies on addiction, Sussman and Sussman (2011) identified the key features of addiction as (a) engagement in the behaviour to achieve a specific emotional result in the addict through usage of the substance; (b) preoccupation with the behaviour to obtain the substance; (c) temporary satiation; (d) loss of control; and (e) the experience

of negative consequences. These aspects constitute the cycle of addiction in which the addict is trapped, describing, like the Jellinek Curve, the addict's destructive journey both over time and within the cycle of addiction.

Aspects of this cycle are seen in the following definition by the National Institute on Drug Abuse (United States [U.S.]), which introduces the aspects of brain disorder and mental illness caused by this cycle of addiction. Here addiction is defined as:

> a chronic, relapsing disorder characterized by compulsive drug seeking, continued use, despite harmful consequences, and long-lasting changes in the brain. It is considered both a complex brain disorder and a mental illness. Addiction is the most severe form of a full spectrum of substance use disorders, and is a medical illness caused by repeated misuse of a substance or substances. (National Institute on Drug Abuse, 2014, para. 1)

2.3.1 Time as a defining factor of addiction

The notion of time in addiction is important in the Western medical model. In the American Psychiatric Association (APA) (DSM-V) and World Health Organization (ICD-10) classifications, addiction has been termed "substance use disorder" and has replaced what was previously termed "substance abuse" and "substance dependence" (AA, 2013; Eisenberg et al., 1999). The reason for this revision is the recognition that addiction occurs over time. This has been factored into the new diagnostic approach, replacing the dualistic, all-or-nothing approach used previously to indicate the severity of the substance use. This diagnosis attempts to clarify the complexity of this challenging condition, as seen in the criteria below.

In order for a patient to be diagnosed with a substance use disorder, the APA (2013) requires at least two of the following criteria to be met:

- The substance is often taken in larger amounts, or over a longer period, than was intended.
- There is a persistent desire to cut down or control the use of the substance but attempts to do so are unsuccessful.
- A significant amount of time is spent in activities related to obtaining or using the substance or recovering from its effects.
- The person experiences a craving, or strong desire or urge, to use the substance.
- Recurrent use of the substance is resulting in a failure to fulfil major role obligations at work, school, or home.
- There is continued use of the substance, despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
- Important social, occupational, or recreational activities are given up or reduced because of the use of the substance.
- There is recurrent use of the substance in situations in which it is physically hazardous.
- Use of the substance is continued, despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Tolerance is evident, as defined by either of the following:
  a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or
  b) a markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal is evident, as manifested by either of the following:
  a) The characteristic withdrawal syndrome for the substance
  (refer to criteria a and b of the criteria set for alcohol withdrawal), or
  b) Alcohol (or a closely-related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Use a criteria count (from two to eleven) as an overall severity indicator.

Use the number of criteria met to indicate mild (two to three criteria), moderate (four to five), and severe (six or more) disorders.

These DSM-V criteria were used by the psychiatrists who diagnosed the patients who participated in this study.

Thus we see that the orthodox conception of addiction, as stated by the American National Institute on Drug Abuse (2008) is that addiction is " a chronic, relapsing brain disease characterised by compulsive drug seeking and use," despite harmful effects with "genetic, psychosocial, and environmental factors influencing its development and manifestations" (Morse & Flavin, 1992, p. 1012). This broader and more holistic conception is supported by the medical establishment, including the American National Institute of Alcohol Abuse and Alcoholism, the American National Institute of Drug Abuse, the American Medical Association, the British Medical Association and the World Health Organization. In addition, research findings in neurobiology increasingly support emerging psychological understandings (Kemp, 2018).

2.3.2 Addiction as a chronic disease

The understanding of addiction as a chronic medical disorder places it in the same category as other chronic illnesses which require lifelong treatment, such as adult-onset diabetes, hypertension and asthma (O'Brien & Thomas McLellan, 1996). The notion of chronicity reframes the phenomenon of relapse from a failure of treatment to an expected aspect of a longer-term treatment and healing trajectory. In fact, the relapse rate for addiction (54%) is comparable with those of other chronic illnesses such as hypertension (50–70%), asthma (50–70%) and diabetes (30–50%) (Heery, 2013). All of these disorders are chronic, subject to relapse, and are influenced by genetic, developmental, behavioural, social and environmental factors. Where addiction differs from other chronic illnesses, however, is in the risk it poses to others (MacCoun, 1998; Marlatt et al., 2012). In other words, this is a dangerous disease not only to self, but also to others. This cannot be said of diseases such as asthma, hypertension and diabetes. The following diagram illustrates the harm done to others through addiction — especially addiction to alcohol, heroin, crack cocaine, tobacco and cannabis.

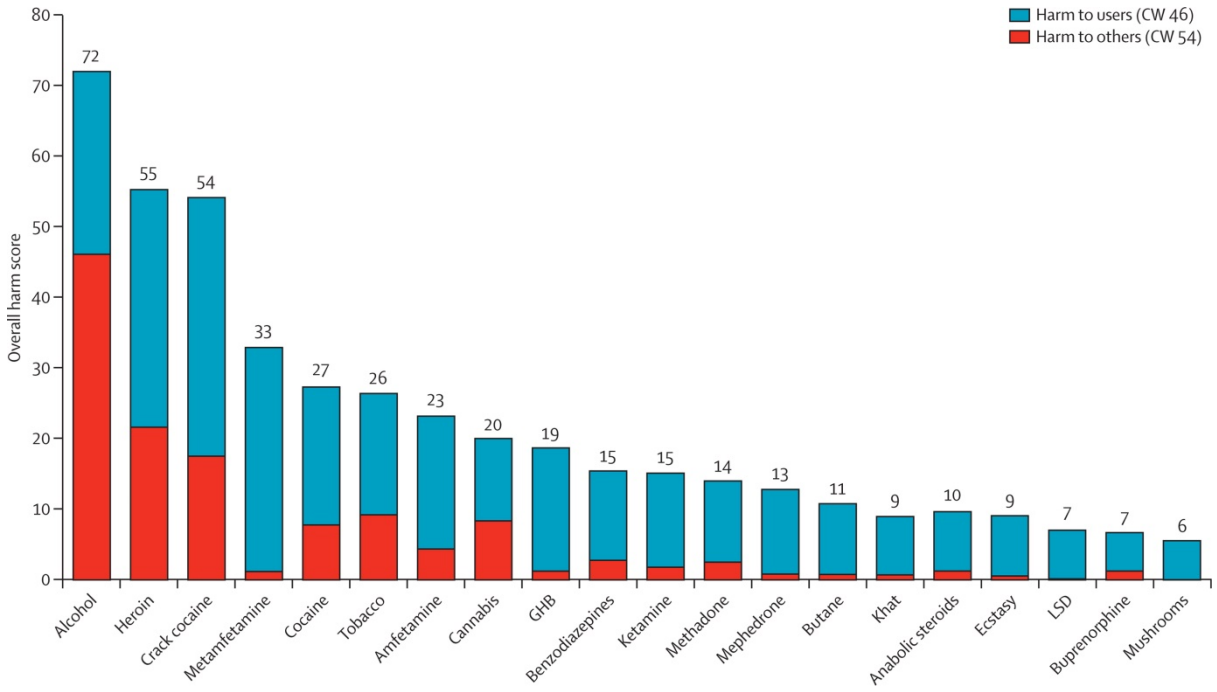


Figure 2.2 Estimation of the relative harm to users and to others caused by addiction to various substances (Nutt, King, & Phillips, 2010)

Despite the fact that in recent years the research demonstrating that addiction is a chronic disease has been well publicised, many continue to hold a moralistic view of addiction (Miller, 1991), seeing addicted people as immoral, weak-willed or as having a character defect deserving of punishment or incarceration (Matthews et al., 2017). The stigma, shame and guilt associated with addiction often continue to weigh down both the addicts and their families (Center for Substance Abuse Treatment, 1994). This may be due, in part, to the 'harm done to others' aspect of the disease.

Addiction is, in truth, a manageable disease, with relapse indicating a need for intervention (Tull & Aldao, 2015). From my clinical experience with this recovery group in particular, I have seen that understanding relapse as a learning opportunity can encourage a steady trajectory of recovery over time. Relapses often provoke shame and guilt in the recovering person; thus, the sooner treatment is resumed, the easier it is for the person to work through the relapse and move forward (Freedman, 2018).

2.3.3 The lived experience of addiction

Despite addiction being, on one level, a manageable chronic disease, the nightmare which is often the lived experience of an addict cannot adequately be captured by a presentation of facts and diagnostic criteria. This section paints a picture, based on my professional experience, of the total destruction of the person that occurs. This will later be contrasted with the profound changes that occur in all aspects of the person of the addict through recovery.

While an addiction begins with the pursuit of pleasure, relief from pain, or some other form of emotional regulation or soothing, as it continues a progressive breakdown in the addict's self and life occurs. Addiction is also characterised by the breakdown of interpersonal relationships, resulting in social isolation and loss of a broader sense of life holding meaning, with eventually the addict's focus narrowing only to the substance of choice (Kemp, 2018). Over time, addiction severely impairs aspects of the person's personality and life, including health, relationships, work and financial well-being. Research has demonstrated links between substance use and health, crime and sexual behaviour (van Heerden et al., 2009).

Addiction can be understood as an attempt to alter the emotional reality of the individual's life; as such, it results in a form of personal self-deception (Kemp, 2009). From a Freudian understanding of addiction, the psyche contrives an artifice to maintain this deception so that the addict can continue chasing his perceived pleasure, while defending against any resultant harm. Initial periods of time spent in this emotionally altered state do not pose lasting problems. However, through increased use, the effects of addiction become more pervasive and the individual must begin to rationalise the behaviour in order to make sense of this state of being. Addiction thus starts as an emotional deception and evolves into a total self-deception. Over time this deception becomes a way of being, which alienates the addict from both herself and everyone else. Lying to oneself thus easily develops into a capacity to lie to others. This increasingly deceptive behaviour contributes to the destructive effects resulting from ongoing use of the substance of choice. If it did not, the addict would realise the damage done and surely stop.

Kemp (2011) provides a vivid description of the increasingly destructive progression of addiction over time as a withdrawal from the world and a correlated narrow existence.

The lived-space of the addict is then emptied, not only of human contact, but also of things. Meaning, which is derived from the lived-contact with others and things of value, slowly dissipates. (Kemp, 2011, p. 338)

The addict turns to the substance of choice to regain a sense of stability and meaning, resulting in a relentless cycle which consumes them despite the destruction (of self, others and property) it leaves in its wake. This phenomenological lens allows us to look with empathy at the emptiness of meaning and 'entrappedness' of the addict caught in this cycle. Ultimately, the world of the addict collapses, leaving them in a bleak and hopeless space where relationships with self and others are often destroyed. This is often described as reaching 'rock bottom'. At this point, the addict typically comes to the realisation that this cycle will eventually lead to their death, unless they make a choice to recover.

2.4 UNDERSTANDING RECOVERY

"Addiction recovery is a dynamic process influenced by the progressive suffering caused by substances and by the knowledge and attractiveness of alternative rewards. More research focused on the millions of individuals already in successful recovery could shed more light on the factors that make a real difference in facilitating long-term salutary change."

— Kelly (2017b, p. 762)

Recovery is complex, multi-dimensional and dynamic process, as is the psychosocial environment in which each recovery unfolds (Laudet & White, 2008). The quote above highlights the importance of a study such as this one in terms of looking at the "factors that make a real difference in facilitating long-term, salutary change". This section locates the study in the field of addiction recovery, exploring the motivations and gains associated with recovery and the culture and history of the recovery movement.

2.4.1 Defining recovery

The term "recovery" has been used freely in the area of addiction for over half a century; however, it is only recently (since about 2005) that it has begun to be defined and specifically applied in the context of addiction. Initial research begun by Laudet (2007),

who operationalised the term, focused on the relationship between substance and abstinence. Researchers began to explore the definition and meaning of "recovery" in 2005 when the Center for Substance Abuse Treatment (CSAT), a division of the Substance Abuse and Mental Health Services Administration (SAMHSA), set up a committee of experts to do this (see Table 2.1) (CSAT, 2005; Laudet et al., 2006).

The following year, the Betty Ford Center published the first expert and stakeholder panel definition of "recovery" as a "voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" (Belleau et al., 2007, p. 221). Other definitions have since been formulated, and almost all have in common the notion that recovery goes well beyond the reduction of or cessation of substance use, and extends to improving functioning in key life areas (U.S. Substance Abuse and Mental Health Services Administration Office of the Surgeon General [USSAMHS], 2016).

Table 2.1 Key definitions of recovery developed since 2005 (Kelly & Hoeppner, 2015, p. 2)

Source	Year	Definition
Center for Substance Abuse Treatment (CSAT)	2005	Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life
American Society of Addiction Medicine	2005	A patient is in a "state of recovery" when he or she has reached a state of physical and psychological health such that her/her abstinence from dependency-producing drugs is complete and comfortable
Betty Ford Institute Consensus Panel	2006	A voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship
UK Drug Policy Commission	2008	The process of recovery from problematic substance use is characterized by voluntarily-sustained control over substance use which maximizes health and well-being and participation in the rights, roles and responsibilities of society
Scottish Government	2008	A process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society
SAMHSA	2011	Recovery from mental disorders and substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential

The definition of the United Kingdom Drug Policy Commission (2008) leaves open the possibility of "controlled drinking" — an idea which was popular in the 1970s — where long-term research shows a small percentage of followers who managed to stay sober (Miller et al., 1992). The SAMHSA (2012) definition emphasises the trajectory of recovery, which could include relapse, over the total control of the substance. It also acknowledges that there is a connection between the psychology of the addict and the manifestation of her addiction. The concept of recovery is further understood by the SAMHSA's criteria for recovery, where the person is able to address their problems as they arise without a relapse being triggered, has a truly honest relationship with at least one other person, is aware of personal boundaries, and practises good self-care (CSAT, 2005).

Recovery has been conceptualised in various ways — from being a continuous process containing benefits from lessons learned in treatment, to consisting of various separate and discrete stages, to specific changes in attitude and belief (USSAMHS, 2016). Some models have been based on the idea of recovery consisting of stages (Prochaska & DiClemente, 1983). For Boyarsky and McCance-Katz (2000), recovery can

> best be conceptualized as a dynamic, fluid state that can shift from pre-conceptualization of substance modification on one end of the spectrum through the acute withdrawal or abstinence syndromes, to early abstinence and extinction of symptoms (cravings) at the opposite end of the spectrum. (p. 2096)

According to other researchers, recovery is an opportunity for addicts to begin abstinence, change dysfunctional thinking and behaviour, regain good health and reduce the wake of chaos in their lives (Witbrodt et al., 2015). Almost all of the more recent definitions of recovery go beyond abstinence and focus on traits and qualities in the life of the recovering addict (as shown in Table 2.1).

Recovery is presently considered to be non-problematic substance use (or total abstinence) and improved functioning in areas such as physical and mental health, employment, and economic, family, and social life. Fundamental to this view is that recovery is a dynamic and individual process in which the combination of factors defining recovery is individually determined and may well change over time as recovery progresses (USSAMHS, 2016). There are many paths to recovery and it is up to

individuals to choose the one that is right for them. People will choose their pathway based on their cultural values, their socioeconomic status, their psychological and behavioural needs, and the nature of their substance use disorder.

Recovery is understood differently across different cultures and communities. In the United States, African Americans are more likely than those of other racial backgrounds to see recovery as requiring complete abstinence from alcohol and drugs (USSAMHS, 2016). Among Native Americans recovery is inherently understood to involve the entire family and community (Matthews et al., 2017; USSAMHS, 2016). This would resonate with the notion of ubuntu lived by many African people in South Africa. On the other hand, European Americans — as well as white South Africans — would tend to define recovery in terms that are more individual. Within some communities, recovery is seen as being aligned with a particular religion; in other communities, such as the AA fellowship, recovery is explicitly non-religious but is instead considered 'spiritual'. Still other communities, such as LifeRing Secular Recovery, SMART Recovery, and Secular Organization for Sobriety, view recovery as an entirely secular process (Zemore et al., 2018). A person in recovery can find a group or recovery practice that fits with his or her own values, culture, beliefs and personality to provide appropriate support.

The vision of the recovery movement is echoed in the working definition of recovery offered by one of the leading writers in the field, William White. For him, recovery is "the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilise internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life" (White, 2007, p. 236).

A successful example of a national approach to recovery is found in Portugal, which decriminalised drugs in 2001, allowing people to carry up to 10 days' supply of drugs with them and providing free access to treatment (Hughes & Stevens, 2010). Since then, drug use has declined significantly among the age group 15–24 years — which is the most vulnerable group worldwide and most likely to use drugs. Drug-induced deaths have declined sharply, HIV-infection rates among injecting users have declined, and there has been a significant decrease in drug-related arrests and a concomitant surge in visits to health centres for drug treatment (Hughes & Stevens, 2010).

2.4.2 Conceptions of and misconceptions about recovery

"Recovery begins with the committed decision to stop using the substance(s) of choice, and abstinence is typically the first step to recovery." (Freedman, 2018, p. 7)

Most addicts in this study explained that they had chosen to recover because they had reached "rock bottom", or were "sick and tired of being sick and tired". For others, there was a specific turning point — like the death of a using- or drinking-buddy or someone they loved who they were not there for, or that they caused a death, and this broke through the hold that denial had on them sufficiently for them to enter rehab.

One misconception around recovery is that, as with other chronic health conditions, substance use disorders can be made to go into remission by the addict cutting down or stopping the substance of choice; it is likely that in occurrences where this appeared to have happened that these disorders were not extremely serious to begin with (USSAMHS, 2016). Much writing exists on the phenomenon of 'maturing out of addiction' as well, where the addict is considered to 'outgrow' the disease (Lee et al., 2015; McIntosh, 2014). For some people with far less serious substance use disorders, 'remission' is the end of a phase in their lives to which they do not assign much significance. However, for many others whose addiction is more severe, remission is a component of a far broader transformation of their behaviour, attitude and identity. That change process encompasses how they think about themselves and their experience and choices regarding substances. Those people describe themselves as being 'in recovery'. These people would be professionally diagnosed as having a substance use disorder.

Serious addiction is a chronic condition that generally involves cycles of abstinence and relapse, possibly over several years following attempts to change (U.S. Department of Health and Human Services Office of the Surgeon General, 2016). Thus, sustaining remission among those seriously affected typically requires a dedication to a personal programme of sustained recovery management (USSAMHS, 2016). Even though it includes relapse, the general trajectory is of a positive and ultimately successful recovery.

2.4.3 Brain and lived changes through the process of recovery

Recovery from addiction is extremely difficult due to the immediacy of reward associated with substance use, coupled with changes in brain chemistry that occur with long-term abuse of the substance, which affect higher order executive functioning both in the immediate situation and over the longer term (Bates et al., 2013). According to Kemp (2011), who uses an existential-phenomenological lens to look at the contrasting worlds of addiction and recovery, while

> active addiction is characterized by narrowness and withdrawal from the world; recovery from addiction entails an embrace of the world. This movement into recovery is described as broadening and reaching out, a way in which the world is opened up to be experienced in all its breadth and spiritual significance. (p. 338)

Positive changes happen in recovery. Out of 35 possible important positive life changes endorsed by participants in one study, the top criteria for recovery included: handling negative feelings without using substances like I used to (97%); being able to enjoy life without using substances, like I used to (98%); being honest with myself (99%); and taking responsibility for the things that I can change (98%) (Kaskutas et al., 2014).

Kaskutas et al. (2015) hypothesised that changes in recovery would not be prominent in those in early recovery, who had not yet grasped the essence of recovery and needed time to consolidate their understanding of it. However, their study indicated that although the meaning of recovery is grasped early on, it takes time to realise it.

The results of a seminal and comprehensive study of how people define recovery, involving over 9 000 previously addicted participants from a range of recovery pathways (Laudet, 2007), were very similar to both of Kaskutas et al.'s later studies (Kaskutas et al., 2014; Kaskutas et al., 2015). For Kaskutas et al. (2014), it was important to understand that recovery goes "beyond substance use e.g., self-care, concern for others, personal growth, and developing ways of being that sustain change in substance use" (p. 1001). Laudet's (2007) study found that almost all of the participants (98%) reported characteristics that met formal medical criteria for a severe substance use disorder, and that three-quarters labelled themselves as being "in recovery". This study shed light on how varied the participants' perceptions and definitions of recovery were: 86% saw abstinence as part of their recovery; 'being honest with myself' was endorsed as part of

recovery by 98.6%; other aspects associated with recovery for a high number of participants were ‘handling negative feelings without using alcohol or drugs’ and ‘being able to enjoy life without using’. These are key elements in recovery which resonate with the findings of this study.

McMillen et al. (2001) identified positive changes due to recovery, which included changes in life priorities and increases in self-efficacy, family closeness, intimacy with others, spirituality and compassion. For other authors, with other participants, recovery was considered to be a process of discovering and fostering self-empowerment, learning self-redefinition, returning to basic functioning and improving their overall quality of life (Oliveira-Maia et al., 2016).

In terms of recovery involving more than just abstinence, Hewitt (2004) described the post-traumatic growth that individuals participating in a qualitative study experienced after discontinuing alcohol and drug use. His study expanded on a phenomenon reflected in the AA concept of gratitude, when recovering alcoholics report viewing their alcoholism as a gift that has brought them to a greater sense of wholeness, fulfilment, or self-actualisation because they confronted their addiction. Hewitt found that many individuals marked a contrast between the ‘craziness’ and chaos of their previous lives, and the calmness and sanity that was characteristic of their present lives in recovery.

Adding further to the diversity of definitions associated with recovery, in recent years the term has been increasingly applied to recovery from mental illness. Studies of people with schizophrenia, some of whom have co-occurring substance use disorders, have found that recovery is often characterised by increased hope and optimism, and greater life satisfaction (Drake et al., 2006).

The importance of having hope and believing in the possibility of a renewed sense of self and purpose is an essential motivator of recovery. Seeking out a source of hope and inspiration helps individuals in recovery to desire change and foster motivation to embark on and/or sustain a process of change (Young & Ensing, 1999). Participating in a group with role models who are further down the road of recovery than oneself is one source of hope and motivation.

Irving et al. (1998) found that greater hope and increased goal-oriented thinking were positively correlated to length of time abstinent, quality of life and self-efficacy. In other

studies, listening to peers share experiences about how they dealt successfully with substance-related problems gave individuals in recovery confidence in dealing with their own situations (Hunter, 2007; Mackenzie et al., 2015).

2.4.4 Incidence of successful recovery

Reported rates of recovery from addiction vary widely. Evidence from the U.S. has indicated that approximately 50% of individuals diagnosed with a substance use disorder eventually progress to a stable state of recovery lasting a year or longer (USSAMHS, 2016). Data from across six large studies indicated that approximately 10.3% of adults in the U.S. are in remission from a substance use disorder (White, 2012).

Epidemiologic studies in the U.S. have shown that approximately 58% of individuals with chronic substance dependence achieve sustained recovery; recovery rates vary from 30–72% across studies, however, and depend on the severity of the disorder (U.S. Department of Health and Human Services Office of the Surgeon General, 2016). A national survey in the U.S. conducted on behalf of Faces and Voices of Recovery found that approximately half of individuals who self-identified as “in recovery” or “formally addicted to alcohol and other drugs” reported having been in recovery for more than five years; 34% reported 10 years or more of stable recovery (Sheedy & Whitter, 2013). In another study, only after four to five years of stable recovery did the risk of relapse drop below 15%, which is the level of risk that people in the general population have of developing a substance use disorder (White, 2012).

Detailed statistics of this nature are not available on addiction recovery in South Africa, which is discussed later in this chapter.

2.4.5 A history of recovery

Recovery is not an easy road, and can take many years, involving numerous interventions and relapses as well as psychiatric, psychological and mutual-aid support.

The earliest research in the field of addiction recovery began in the U.S. about 150 years ago by documenting the traditional supports for the addict (namely, mutual-aid twelve-step programmes and professionally focused addiction treatment) (White, n.d.). As happens in the present day, addicts were treated typically in a hospital-like setting, 'dried out' and then discharged as 'rehabilitated' back into the world. At that point the addict was considered to be cured — thus revealing the pervasive misunderstanding that discharge is the end of the journey of recovery and not the real beginning point.

The thinking around addiction shifted around the turn of the millennium, with the new focus broadening to include recovery support systems. According to William White, who has amassed a collection of research and writing on recovery, for over two centuries recovering addicts and their families have spearheaded efforts to treat and sustain addiction-related problems through twelve-step programmes, medically and religiously focused treatment institutions and advocacy groups (White, n.d.). This increased dramatically in the U.S. from the 1960s to the 1990s, with recovery community centres, organisations, homes, schools, industries and ministries. This shift has been significantly named the "culture of recovery" (White, 2008b).

Between 1960 and the early 1990s, research on recovery increased dramatically, due primarily to the emergence of recovery as a cultural and political phenomenon as manifested in the increase of mutual-aid groups (White, 2008a), which have proven effective in facilitating and sustaining recovery.

This naming of recovery as its own discipline and movement highlights the main shift away from the long-standing stigmatising of addiction, towards a more optimistic and positive solution-focused recovery paradigm (El-Guebaly, 2012; Laudet & White, 2008, White, 2008b). Recovery came to be seen as something that lasts for the rest of one's life and in which one has a recovery career. In addition, this shift supports the notion that addiction is treatable, emphasises the focus on post-discharge processes, and underscores the importance of the recovery trajectory and the active embracing of life and its possibilities again.

An overarching goal of the new recovery-oriented systems of care (Kelly & White, 2011; White, 2008a) is that they are to be a home for those in recovery in a recovering community, as part of life — not separate and removed from it, stigmatised, punished and

pathologised, but supported, included and understood. Those in recovery who are working in recovery-orientated systems of care have come to be known as recovery practitioners as they are role models in the recovery community.

2.4.6 The recovery movement

In recent years, legislators, service providers, clinicians and others have spearheaded a recovery movement with a vision not just of eliminating or reducing the use of a substance, but as an organising principle and goal for services related to substance abuse (Laudet & Humphreys, 2013). At the forefront of this movement has been the international lobbyist organisation Faces and Voices of Recovery, which has an estimated membership of over 23.5 million adults in the U.S. — representing 10% of recovering adults (Laudet & Humphreys, 2013) — and has a presence in South Africa (FAVOR SA, n.d.).

FAVOR SA is a lobby movement that is part of the international movement that links identities to recovery, thus challenging stigma and anonymity. While it accepts that recovery can be anonymous, it encourages individuals to tell their stories and people in recovery to be supported. This movement tries to overcome shame and normalise and celebrate addiction recovery. FAVOR SA hosts a film festival in Cape Town every year and members speak publicly, often. It does considerable advocacy work, including public marches.

In 2005, at a national summit in the U.S., it was recognised that recovery-oriented systems of care are as complex and dynamic as the process of recovery itself (CSAT, 2006). A recovery-oriented systems of care approach was seen at this summit to support individuals and their self-direction in recovery, as well as building and supporting resilience in them and their families and allies, while recovering from their addiction problems. This approach is not judgemental — it is accepting and attempts to eradicate shame, guilt and blame in favour of accurate and compassionate professional treatment that is adapted over time. It also attempts to do away with the grandstanding of any one approach over any other, and any one pathway to recovery over any other (CSAT, 2006). Recovery is an open-armed movement and the lifelong process it embodies can and does happen for those who want it.

Implicit in the concept of the recovery movement is a set of values and beliefs which include that those struggling with addiction have worth and dignity, that stigma and shame need to be combated, that there should be access to treatment for everybody who wants it and that those in recovery and their friends and families have valuable experience to share with others — including individuals with substance use disorders, families, treatment professionals, and even entire health care systems. The flexibility of this approach encompasses and accommodates the community of recovery practice in this study easily.

2.5 ADDICTION AND RECOVERY IN THE SOUTH AFRICAN CONTEXT

The addiction aftercare recovery group that is examined in this study was located in South Africa. The male and female participants represented various races and different cultures and socioeconomic classes within South African society. An understanding of the historical and contemporary reality of addiction and recovery in South Africa is thus essential to understand the context of the group discussed in this study. The lack of access to adequate recovery resources is particularly salient to the significance of this study, which emphasises the relative cost-effectiveness and efficacy of group work in the addiction context.

2.5.1 The incidence of substance abuse in South Africa

In 1994 former South African president Nelson Mandela, in his first opening address to parliament, highlighted the scourge and urgency of the drug and alcohol problem in South Africa (South African Drug Advisory Board [SADAB], 1999). He said that substance abuse is a key factor in "crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability, as well as the escalation of chronic diseases such as AIDS and tuberculosis" as well as injury and premature death (SADAB, 1999, para 1). Since South Africa's integration into the international community in 1994, the country has increasingly become a target for drug traffickers due to the increased access to South Africa through air travel, the extensive land transportation infrastructure, and the fact that South Africa has long, porous borders which are poorly controlled (SADAB,

1999). The availability of modern international telecommunications, Internet and banking systems has facilitated this as well (SADAB, 1999).

Changes in South Africa's social, political, cultural, economic and legislative structures have made the country increasingly vulnerable to drug use post-apartheid (Peltzer et al., 2010). There is a positive correlation between the pressure which rapid modernisation places upon citizens of all cultural backgrounds — with a concomitant decline in traditional social values, customs, relationships and forms of family structure — and the increase in the availability and use of substances (Ramlagan et al., 2010). Large-scale emigration has depleted the middle-class sectors of the population in terms of loss of skills and capital. In addition, the slow redistribution of economic power has impeded social transformation, engendering widespread frustration and desperation. This, in turn, contributes to the high crime rate, with youth who use substances being disproportionately linked to criminal activity (Peltzer et al., 2010).

In 2012, a study was undertaken to understand alcohol use trends and related harm among youth in South Africa between 1998 and 2008. The method used was a review of four national prevalence and two sentinel surveillance studies. Data was extracted to Epi Info (version 7) and chi-square analyses were undertaken. The results showed that lifetime alcohol use remained stable but high at 20–25% and 49.1–49.6%, according to South African Demographic and Health Survey (SADHS) and Youth Risk Behaviour Survey (YRBS) data, respectively. The age of starting to drink remained stable, with 12% of adolescents having their first drink before the age of 13. Homicide, violence, suicide and unintentional deaths were significantly associated with blood alcohol concentration (Ramsoomar & Morojele, 2012).

At the same time, there is a big divide between the rich and poor of South Africa, where two thirds of the country's wealth is held by 1% of the population, and 90% of the wealth is in the hands of 10% of the population (Meiring et al., 2018). In a 2018 newspaper article focusing on the city in which the addiction group is located, the following was written:

> Whoonga is a heroin-based drug mixed with a variety of other substances, including medicine, washing powder and sometimes rat poison. Selling in a straw for between R18 and R30, heroin is used by a diverse clientele who buy nothing fewer than 30 straws a day, police say. (Khanyile, 2018, para. 2–3)

The article states that there is a drug for every price range, and that "Ecstasy sells for R40 a tablet, crack cocaine and Mandrax at R50 a tablet, and cocaine powder goes for anything between R250 and R300 a gram" (Khanyile, 2018, para. 4).

Prevalence rates for substance abuse in South Africa are particularly high, with recent estimates demonstrating that drug use is twice the world average, and with the socio-economic consequences of such usage costing the country in excess of R130 billion per annum (Ramodibe, 2011). Results from epidemiological studies by Pluddemann et al. (2007) and Pluddemann et al. (2010) found that alcohol, cannabis, heroin and crack cocaine feature amongst the more common substances of choice among patients at treatment centres, with the abuse of methamphetamine being particularly high amongst adolescents in the Western Cape and 'sugars' (a low quality heroin and cocaine mix) being the drug of choice for Indian males in Durban.

While South Africa has recently decriminalised cannabis (2018), already in 2003 Interpol estimated the amount of land under cultivation for cannabis to be at 1,000–1,200 hectares, placing South Africa among the top four herbal cannabis sources in the world (Menard et al., 2001). A United Nations World Drug Report stated that in 2013, 7% of the South African population abused narcotics, with one in two South Africans using them regularly. Nearly 4% of the population uses cannabis regularly, with 38.4% of users being treated for cannabis dependency, according to a survey of 26 453 participants in 2012 (Peltzer & Phaswana-Mafuya, 2018)

In conclusion, from my own experience of working in the area, addiction is rife in all aspects of South African society, where members of all social classes use addictive substances socially. The use of traditional beer and marijuana is justified by certain cultural practices within South Africa as a conduit to speak to the ancestors. The use of alcohol is closely linked with masculinity. The use of cocaine is associated with wealth. Many celebrations feature toasts using champagne or other forms of alcohol; many middle-class people have a glass of wine or two at the end of a day to relax. Both gin and Valium have been called 'mother's little helper'. There is a substance of choice available for willing users at every social and economic level, from expensive cocaine, right through to TIK and Whoonga.

2.5.2 The incidence of alcohol use and addiction in South Africa

Until the late 1990s, the availability of substance abuse data from South Africa was very limited and came primarily from ad hoc cross-sectional studies, often conducted in a single location, and from information from police arrests and drug seizures, mortuaries and school surveys (van Heerden et al., 2009).

In 1996, the South African Medical Research Council (SAMRC) and the Department of Psychology at the University of Durban-Westville (now part of the University of KwaZulu-Natal) launched the South African Community Epidemiology Network on Drug Use (SACENDU) with financial support from the World Health Organization (Parry et al., 2002). SACENDU is a nation-wide network of addiction researchers, specialists and policy makers. Members meet twice a year and present community-level public health data on substance use trends, which is published biannually. While SACENDU provides detailed data on treatment demand, it only reports on government-funded inpatient treatment programmes, and thus does not provide data on patients at private treatment programmes, those receiving psychiatric care that may be linked to addiction, or the longer-term recovery process which is the focus of this study.

Other than the SACENDU data, the only nationally representative epidemiological study of alcohol, drug and psychiatric disorders that has been carried out was the South African Stress and Health Survey (SASH), which was conducted between 2002 and 2004 with the primary aim of flagging mental disorders in adults. The survey found the lifetime prevalence of AOD use disorders to be as high as 13.3% among South African adults, with a past-year prevalence of 5.8% (Dada et al., 2018). The study found that while alcohol is still the most commonly used substance in South Africa, other substances such as cannabis and methamphetamine are also widely used, increasingly among women. It was estimated that the cumulative occurrence of alcohol use was 38.7%, of tobacco smoking 30.0%, of cannabis use 8.4%, of other drug use 2.0%, and of extra-medical (including prescription and non-prescription medications) psychoactive drug use 19.3% (van Heerden et al., 2009). There were statistically significant associations between males and alcohol, tobacco, cannabis and other drug use (van Heerden et al., 2009).

Commonly cited figures, such as that one in five adults abuses drugs and alcohol, emanate from a 2009 study published in the South African Medical Journal, which in turn was

based on the SASH 2002–2004 study, and there has been little research in the way of similarly comprehensive studies since then. In this study, 4 351 adults were interviewed using the paper-and-pencil version of the World Health Organization Composite International Diagnostic Interview (CIDI). Findings were given for lifetime use, socio-demographic use correlates, and age of cohort predicting lifetime use for four classes of drugs (van Heerden et al., 2009). While data from the SASH study is now a bit dated, there have been no studies conducted since with the same degree of rigour (B. Myers, personal communication, November 24, 2018).

Other investigations in South Africa and elsewhere have found that substance use correlates with certain sociodemographic characteristics: those who use drugs more frequently tend to be male (Peltzer et al., 2010; van Heerden et al., 2009), adolescent (Peltzer et al., 2010), belong to specific population groups — particularly mixed race and white people, in the South African context (Peltzer et al., 2010; van Heerden et al., 2009), earn lower incomes or are not employed (Peltzer et al., 2010), and live in urban areas (Peltzer et al., 2010). Certain health risk behaviours, as well as common mental disorders (major depression and anxiety disorder) (Conway et al., 2016; Lai et al., 2015), alcohol use disorders (Teesson et al., 2012), HIV risk behaviours (Meader et al., 2016) and criminal victimisation (Walsh et al., 2014) have been found to be associated with substance abuse.

2.5.3 The social impact of alcohol addiction in South Africa

For most major drugs, South Africa was well above the average usage worldwide with alcohol the most frequently consumed addictive substance (van Heerden et al., 2009). It is estimated that in excess of five billion litres of alcohol is consumed annually. This is likely to be higher still if sorghum beer is included, and equates to 9–10 litres of pure alcohol per adult (Seggie, 2012). The annual treatment cost associated with alcohol to the government was approximately R78 billion in 2014 (Matzopoulos et al., 2014). In South Africa, one in three adults reported drinking alcohol, while one in seven reported binge drinking daily (Vellios & Van Walbeek, 2018).

Alcohol is also a major contributor to the burden of disease (Parry et al., 2011). A 2010 analysis of 67 risk factors and risk-factor clusters for death and disability (Lim et al.,

2012) found that alcohol was the third leading risk factor for death and disability, accounting for 5.5% of disability-adjusted life years (DALYs) lost globally, with the highest risk factor in sub-Saharan Africa (Baker et al., 2004).

Overall, in 2015, approximately 62 300 adults died from alcohol-attributable causes in South Africa, with 60% of deaths occurring in people in low and 15% in high socio-economic status groups (Probst et al., 2018).

Between one third to a half of arrestees in Cape Town, Durban and Johannesburg charged with offences categorised as "family violence" reported being under the influence of alcohol at the time of the alleged offence in a 2002 SAMRC study (Matzopoulos et al., 2007). Among Grade 8 and Grade 11 learners in Cape Town, a significant association was found between the use of alcohol and the number of days absent from school in a given month. Learners who consumed alcohol were found to be required to repeat a grade at school 60% more often than their peers (Weybright et al., 2017).

2.5.3.1 Addiction in the workplace

Within the South African workplace, substance abuse among workers is both directly and indirectly harmful to the health of employees, their colleagues and their families, as well as placing workers at risk for various social and occupational difficulties (Burnhams et al., 2014; London et al., 1999). It also exacts an enormous toll on human resources, productivity, the financial status of companies and the economic situation of the country as a whole (Berking & Wupperman, 2012). In 2009, the annual cost to the country of alcohol abuse alone — in terms of absenteeism, lost productivity, health and welfare costs and alcohol-related crime — was estimated at around R37,9 billion, representing 10% of South Africa's Gross Domestic Product (GDP), or as much as 12% (Matzopoulos et al., 2014). In the Cape, workers' wages — particularly in the winelands — were often paid using the 'dop system' (alcohol in lieu of money) (London et al., 1999). It has been suggested that this could be one reason for South Africa — and particularly the Cape, where the winelands are — having one of the highest rates of Foetal Alcohol Syndrome (FAS) in the world; some studies have ranked South Africa as having the highest rate of FAS (May et al., 2007).

2.5.3.2 The role of addiction in crime

The Central Drug Authority (CDA) estimated that between June 2010 and March 2011 around two million people in South Africa could be classified as "problem drinkers" and that 7 000 people died per year from drunk driving (Department of Social Development, South Africa, 2011). According to South African Police Services (SAPS) figures published in 2009, 60% of crimes nationally were related to substance abuse; 65% of murders were related to alcohol (Seedat, Stein, et al., 2009). This did not include the unreported figures on sexual violence, but the fact that South Africa has the highest rate of intimate femicide is important and it is likely many of these murders involved perpetrators who were intoxicated (Seedat, Van Niekerk et al., 2009).

Drugs transported through South Africa are also finding their way into the local market, and desperate and unemployed South Africans have been lured by syndicates into becoming drug couriers with promises of easy money (Joseph, 2013).

South Africa has always been known for high crime statistics, but when the perpetrator has been using an addictive substance at the time, the addition of sadistic and unnecessary violence makes the crimes horrific in the extreme. Although these statistics are dated, SAPS data showed a 123% increase in drug-related crimes from 2003/2004 to 2013, and that 54% of violence-related deaths and 52% of transport-related deaths were alcohol-related (Van der Linde, 2015).

2.5.4 The provision of treatment in South Africa

The availability of support for recovery from addiction in South Africa must be understood against this complex backdrop. While addiction is rife in every sector of the population, the provision of recovery resources is both inadequate and inequitable. The long shadow of apartheid remains, and racial, gender and class disparities continue to characterise treatment access, with women and black South Africans still underrepresented in the government services provided (Myers et al., 2008).

Recent statistics on the provision of treatment by the government were hard to find. In my attempts, I contacted Prof. Charles Parry, a substance abuse epidemiologist/policy analyst and the Director of the Alcohol, Tobacco & Other Drug Research Unit of the

South African Medical Research Council (SAMRC), and Prof. Bronwyn Myers, Chief Specialist Scientist in the Alcohol, Tobacco and Other Drug Research Unit of the SAMRC. I also conducted numerous searches on Google, Google Scholar, Ebsco Host and various South African databases.

The only statistics that I could obtain were from 20 years ago. Even then, the provision of treatment facilities was meagre. At that time, these included (Humphreys, 1997):

- 300 aftercare and support centres
- 67 community treatment facilities
- 147 provincial private and psychiatric hospitals
- 12 detoxification centres
- 25 inpatient / halfway houses.

Bronwyn Myers wrote ten years ago that South Africa had provinces that did not have government-funded treatment facilities for the majority of citizens who were not on any medical aid (Myers et al., 2008).

There has been an increase in private clinics that provide good-quality care; however, these come at a cost and therefore are only accessible to the wealthy or those with medical aids, and private treatment is thus inaccessible to the majority of South Africans (Hughes & Stevens, 2010). For example, We Do Recover, a treatment programme with facilities around the world, charges R22 000 to R67 000 for 21–28 days of inpatient treatment. Medical aids typically cover 21 days per year. The treatment options provided by We Do Recover in 2019 were priced as follows (WeDoRecover, 2019):

Treatment on the coast:	R 40 000 per month
Farm outside a minor town:	R 22 000 per month.

The recovery group that is the focus of this study was part of a recovery programme provided by a private clinic, and all the participants were members of a medical aid and would have been covered for their inpatient rehabilitation. As can be seen in the chapter focusing on twelve-step groups and AA, they have more of a presence in cities and more urban and formerly white areas. Even though attempts are being made by AA, there are fewer of these types of resources for other communities and language groups in South Africa.

A 2005 doctoral study which evaluated four KwaZulu-Natal government treatment centres noted that there is a "paucity of financial resources available to many centres" and that "crucial and innovative strategies for treatment and rehabilitation are needed" in which the client must "be given opportunities for self-development and have an equal stake in his/her treatment plan" (Hoosen, 2005, pp. 223–224).

The most recent SACENDU figures, for the second half of 2016, showed 8 787 patients receiving treatment at 75 centres or programmes (Dada et al., 2017); this was down from 10 540 six months earlier, although no explanation was provided for this. An increase in drug use from 3.7% in 2008 to 4.4% in 2012 was observed in a study done in South Africa (Peltzer & Phaswana-Mafuya, 2018). Even though these statistics refer to the years 2008 and 2012, they indicate that a very small percentage of addicts are in treatment. Across the nine provinces of South Africa, between 18% and 47% of patients in treatment reported alcohol as their substance of choice (Dada et al., 2017). Alcohol was found to be the dominant substance of abuse among patients from the Eastern Cape, while cannabis was the most common substance of abuse among patients in Gauteng and KwaZulu-Natal (Dada et al., 2017).

The average age of admission ranges from 28–34 years of age (Burnhams et al., 2014; Harker et al., 2008). Across most sites, alcohol was reported as the primary substance of abuse and the mean age of alcohol admissions was 38–40 years (Burnhams et al., 2014). Most admissions under the age of 20 reported cannabis or cannabis/Mandrax as their primary substance of abuse. The discussion surrounding decriminalisation is particularly relevant to this age group, who should not be considered obvious candidates for criminalisation (Burnhams et al., 2014). On the contrary, they could be perceived as a vulnerable group, and criminalisation will only serve to increase that vulnerability. One study found that the majority of admissions for harder drugs such as cocaine and heroin were from the white population group (Dada et al., 2017).

Despite the great need for substance abuse treatment, recovery rates are low (Myers et al., 2008). A number of factors contribute to this, including structural barriers to treatment use such as cost and geographical location; inadequacy of funds; and barriers within the medical health care system arising from the historical separation of substance use treatment and mental health services in South Africa (Myers et al., 2008). Other factors include the inadequacies of policies to provide sufficiently for the overall need; the

severity of the South African addiction problem; the stigma of addiction; the poor perception of rehabilitation services; and issues around the training, and high turnover, of overworked staff (Myers et al., 2008; Sorsdahl et al., 2012). There are also cultural barriers, such as the importance of drinking in many cultural activities, as well as the stigma, denial, shame and guilt experienced by the addict herself (Freedman, 2018).

Treatment programmes with solid aftercare programmes have far more beneficial results (Parry et al., 2002). The group in this study is one such programme; however, there are very limited aftercare programmes funded by government, which contributes to the limited recovery-response of the addicted population (Humphreys, 1997).

2.5.5 Policy governing treatment

Looking more broadly at policy regarding addiction and treatment, a review of the National Drug Master Plan of South Africa (Parry et al., 2002) demonstrates that various aspects of the problems of substance abuse have not been sufficiently addressed. One of these included the implementation of regular audits of treatment services and prevention programmes. According to a report to Parliament by the SAMRC, a significant criticism was that most primary prevention programmes were initiated with no research basis on their efficacy (Booyens, 2009). A 2012 review of The Third (draft) National Drug Master Plan (2012–2016) and the Department of Health's Mini Drug Master Plan (2011–2014) noted this as they both specified service-quality improvement as a priority (MacCoun, 1998). For Myers, this was critical, as a "failure to extend the current narrow focus on improving access to health services to include a quality focus may represent a missed opportunity to improve the health of South Africans" (Myers et al., 2012).

The Prevention of and Treatment for Substance Abuse Act of 2008 has been criticised for focusing solely on treating those with co-occurring mental disorders and substance abuse disorders, and their detoxification and linked health complications (Myers et al., 2008). Confusion and inadequate service delivery have occurred due to the splitting of the two disorders, resulting in duplication of funding streams and workforces, while inadequate coverage is provided for essential needs (Myers et al., 2008).

2.5.6 Barriers to treatment

2.5.6.1 Staffing issues

High caseloads, inadequate numbers of staff and poor training contribute to a high staff turnover in all treatment sectors (McLellan & Meyers, 2004). These factors affect the image and reputation of addiction treatment services, which, in turn, affects treatment uptake (Myers et al., 2008). The only certified courses that exist for health care professionals include two postgraduate courses recently offered at the University of Cape Town (Pasche et al., 2015). This lack of standardised training limits the quality and capacity of service delivery (Myers et al., 2008).

2.5.6.2 Historical inequity

In apartheid South Africa, race determined access to all social resources, including addiction treatment. Not only were government-subsidised treatment facilities of poor quality and inadequate in number, but most were reserved for whites and were located in urban areas, out of the reach of most other South Africans, resulting in a massive under-representation of addicts from racial designations other than white (Myers et al., 2008; Parry, 1997; Parry & Bennetts, 1998). This has given cause for concern (Myers et al., 2008). At the same time, there is a correlation between poverty and substance abuse and the problems that accompany it; disadvantaged communities thus often have high rates of substance abuse and related issues (Kalichman et al., 2006; Kalichman et al., 2007; Sawyer et al., 2006). The low uptake of treatment services by black and other previously disadvantaged South Africans thus does not reflect a lower rate of addiction in these sectors of the population but rather the restricted access they experience (Myers et al., 2008; Myers & Parry, 2005). It reveals how access was restricted under apartheid but not how it still is, except for the geographical preferencing of urban areas.

2.6 CONCLUSION

In summary, it can be seen that there is a dearth of literature on the present context of addiction in South Africa, highlighting the gap for this particular research. It is clear that the options for recovery provided by government are inadequate, and the options for private rehabilitation are too expensive for the majority of the population. This leaves possibilities for recovery options that are cost effective and that work. One of these options is the aftercare group, such as the one in this study.

There is a lack of addiction aftercare groups in South Africa. The main resources focus on rehabilitation 'stopping' addiction rather than on 'staying stopped' over the long term. This indicates the gap within which this study is located, both theoretically and practically.

The present study demonstrates that an addiction recovery group may be able to offer the client opportunities for such self-development and personal growth, and provide an effective and cost-effective adjunct to the struggling services that exist. The complexities of the South African socio-political-historical context leave its population ripe for addiction, and the need for more appropriate professional services is massive. It is within this context that this study of how individuals recover by participating in an addiction recovery group, and the mechanisms of that group, makes its contribution as an offering, both theoretically and practically.

CHAPTER 3
MODELS FOR RECOVERY IN A GROUP CONTEXT

3.1 INTRODUCTION

The previous chapter discussed different ways of conceptualising and examining addiction and recovery, as well as on addiction and recovery in the South African context. The inadequate provision by the state for rehabilitation, which deprives many addicts of treatment and fails to adequately support the recovery of those who do receive treatment, was explored and contrasted with the expensive treatment options available in the private sector. In this context, the importance of and need for cost-effective and operational aftercare groups in sustaining recovery was highlighted.

This chapter looks at the concept of group recovery, which has been found to be extremely effective in fostering the personal transformation which is essential to recovery (Shelley & Santiago, 2013). The chapter focuses on two models for group work — group therapy and twelve-step recovery programmes (based on the principles of AA) — which are the most well-known approaches used for substance abuse treatment (Panas et al., 2003). The twelve-step model is a form of mutual-aid group in which members gain the support and knowledge that they need through relationships built with other members during attendance of sessions over time, which enable them to sustain recovery and transform their identities. In the group therapy model, a psychologist provides opportunities for members to explore the emotional and interpersonal conflicts that contribute to their substance abuse in a group context. While these two models have different theoretical underpinnings, structures and processes, both emphasise the importance of developing interpersonal relationships as a foundation of the recovery process, in which the group serves as a community of practice for the recovery from addiction. The group in this study was a hybrid of both of these traditions because of the backgrounds of the two co-facilitators (a psychologist and a recovering addict of at least three years' standing). This chapter also highlights the concerns, issues and outcomes that I, myself, bore in mind as the psychologist who co-facilitated the group with three addiction counsellors (one at a time).

While the efficacy and benefits of group work have been demonstrated across many studies, the mechanisms by which they achieve these aims are not well understood (Tonigan & White, 2016). This study aims to fill the gap in knowledge in this area.

3.2 THE BENEFITS OF A GROUP CONTEXT TO RECOVERY

The group setting provides many elements that are important to recovery. The opportunity that it creates to relate to others provides a recovering addict with a safe place to learn the skills and capacity for attachment and relationship, as well as to discuss and practise these new skills with each other. Participants also learn valuable tips and knowledge from other participants who are further down the path of recovery as they share their stories, which they can apply to their lives and then report back on to the group. The group acts as a container and, over time, serves as the substrate of transformation, where participants help each other to engage with significant aspects of recovery and learn ways to manage their issues healthily and differently without reaching for their substance of choice as their only perceived option. The capacity of addicts to tolerate difficult emotions is gradually built up along with a repertoire of new skills and understandings. Participants thus learn how to recover from addiction together while teaching each other both intentionally and unintentionally.

There are many benefits to group work (Garland, 2010):

- Participating in a group fosters self-examination, reflection, belonging and personal growth.
- Group members give positive feedback, which builds the self-esteem of both.
- The member feels seen, visible and that she exists and her problems matter.
- Members learn coping skills from each other.
- Having other people in the room who give feedback and comment on one's narrative, allows the challenging of one's perceptions about oneself from others.

The aspect of having to delay gratification in group work is key to the recovery process of addicts. Having to wait one's turn promotes self-management and encourages one to listen to others and focus on what is happening in the group rather than focusing on

oneself. As thoughts of oneself often dominate the mind of an addict, these other-oriented experiences are essential. These benefits cannot be achieved in an individual therapeutic encounter or a lecture type situation.

The presence of fellow participants reduces an individual participant's reliance on the facilitators. Group participants receive direct and personal comments more easily coming from a fellow group member. Even if such comments are critical, they are typically accepted with the good intentions with which they were made because of the participant's identification with her peers. While family and friends have often grown impatient with the addict, group members are committed to each other's well-being and have each other's recovery at heart. This means that the addict will often pay attention to feedback from another group member when the same feedback from a family member is rejected. A bond of trust exists among group members (Garland, 2010).

The process of recovery involves, to some extent, the recreation of the addict's understanding of self in relationship with another through a process of both self-examination and reciprocal learning as the addict's capacity to synthesise new and sustaining relationships begins to develop within the context of the group (Winship, 2012). Participation in a group also facilitates the expression of intense emotions by a participant without a member becoming overwhelmed, as the experience is shared collectively by the group (Flores, 2013).

3.3 THE TWELVE-STEP MODEL

Alcoholics Anonymous (AA) is the most widely subscribed recovery programme in the world (Kelly et al., 2014). Rigorous studies of its effectiveness indicate that AA and other twelve-step treatment models are at least as effective as other types of intervention (Emrick et al., 1993; Humphreys et al., 2004; Kelly et al., 2006; Tonigan et al., 1996). Quite how AA achieves these positive results is not fully understood, however. Many researchers have called for further study of these mechanisms, not only in AA specifically but also generally. For example:

> What is clear is how little we know about the mechanisms of action in these … treatments for alcohol use disorders. (Longabaugh et al., 2005, p. 245)

> Alcoholics Anonymous (AA) is the most commonly used program for substance abuse recovery and one of the few models to demonstrate positive abstinence outcomes … little is known regarding the underlying mechanisms that make this program effective. (Groh et al., 2008)

> Findings from most studies speak to recovery initiation only, not to the challenges and processes involved in achieving and sustaining long term recovery. (Laudet & White, 2008, p. 2)

> Despite a growing interest in how group membership can positively affect health, little research has addressed directly the role social identity processes can have on recovery from addiction. (Buckingham et al., 2013, p. 1132)

> We're very interested in the dynamics of groups. Until we get a real handle on that, we will not fully understand the process of AA and the mechanisms through which AA involvement influences drinking and related outcomes. (Tonigan in White, 2016, p. 6)

A better explanation of the elements of twelve-step programmes which are effective in helping addicts achieve and sustain recovery is therefore needed (Kelly et al., 2010). This indicates a gap in knowledge regarding the achievement of sobriety outcomes via a group process, which this study aims to fill — not specifically in terms of twelve-step programmes, but in terms of furthering the understanding of recovery group processes and mechanisms via the case study in question.

3.3.1 The twelve-step pedagogy and curriculum

According to the twelve-step approach, the sole criterion to join is the desire to stop one's addiction (AA, 2001). New members are welcome to join at any time and as meetings run on a donation basis, no one is rejected for their inability to pay. Participants may thus represent the full spectrum of society. All meetings begin with the introduction of "My name is xxx and I am an alcoholic (or addict)" — thus initiating acceptance of this aspect of the participant's identity. At these meetings 'old-timers' give testimony to their journey of recovery, giving newcomers a comprehensive view of what recovery in this community is about. These groups are characterised by "the human warmth that fills the

twelve-step meeting room and the amazing patience shown to those who relapse — who are always welcome to begin again" (Alexander & Rollins, 1984, p. 37).

3.3.1.1 The twelve-steps

Table 3.1 shows the twelve-steps that constitute the curriculum which guide members through the process of moving from the periphery to full participation in the recovery group (Lave & Wenger, 1991, pp. 79–80). In each meeting, different aspects of the steps are explained, applied and discussed. Goals are also clearly explained in the "Twelve Steps" which, depending on the group, are typically read aloud at each meeting.

Table 3.1 The twelve steps on which twelve-step programmes are based

The Twelve Steps of Alcoholics Anonymous
1. We admitted we were powerless over alcohol [or any mind-altering substance] — that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practise these principles in all our affairs.

The objective of twelve-step programmes is that by following these steps, participants will change their beliefs regarding their own self-worth and self-esteem, and develop the ability to engage in relationships with others while living a sober life (Carnes, 2001).

3.3.1.2 Transformation of personal identity through relationship

The first step in the AA pedagogy is to encourage the new member to begin to own her new identity as an alcoholic, and become open to learning new ways of approaching and dealing with the many aspects of life:

> So our troubles, we think, are basically of our own making. They arise out of ourselves, and the alcoholic is an extreme example of self-will run riot, though he usually doesn't think so. Above everything, we alcoholics must be rid of this selfishness. We must, or it kills us! (AA, 2001, p. 62)

This appeal distils a clear and critical decision for potential and existing AA members. In short — "embrace recovery and live or reject recovery and die" (Young, 2011, p. 215). This involves a move away from their previous identity as an addict. In fact, the first three steps — the 'surrender steps' — focus on leaving this identity and embracing a new foundation on which to build a recovering identity that is genuine and authentic. The remaining nine steps complete the building of the new identity, which involves making an inventory of all significant relationships, making amends, finding one's place again and participating gainfully in society, and taking total responsibility for one's previous misdemeanours and injustices towards self and others. In this way, recovery begins with a clean slate, not having the past and one's previous behaviour brought up to prevent recovery and trigger relapse.

The readiness and ability to communicate fittingly and genuinely with others predicates a sound recovery along with the knowledge that the newly recovering identity is embryonic, dynamic and developing. As the recovering addict progresses along their new path, relationship with self and others becomes important as does surrender: "We have ceased fighting anything or anyone — even alcohol" (AA, 2001, p. 84). Creating and maintaining healthy relationships is the main goal of AA — despite newcomers and researchers focusing solely on sobriety. "Because liquor was but a symptom" (AA, 2001,

p. 64) of difficulties in relationships, the focus is most often on alcohol and its cessation. However, the AA programme clearly differentiates between the notion of abstinence and that of recovery, as one cannot have recovery without abstinence and abstinence on its own results in the 'dry drunk' phenomenon — when the person, though sober, has not transformed personally at all (Gogek, 1994; Hunter & Salomone, 1987).

The twelve-step approach grounds recovery in relationship through three key aspects of the recovery programme: attending meetings, reaching out to other members to receive and/or provide support, and working the steps with a recovery sponsor. Relationships within the AA group are fostered in a context of fellowship. It is in the meetings that members hear each other's stories and assist each other to break the feeling of isolation and shame, and find a sense of acceptance and belonging. Twelve-step participants were found to relapse significantly less in the year following treatment, regardless of the number of AA meetings attended (Pagano et al., 2004).

Continuous attendance of meetings is one of the basic components of the programme (the AA dictum is "90 meetings in 90 days": in other words, one meeting per day). The emphasis on sharing stories and personal experiences provides participants with a sense of fellowship, relationship and service to each other (Lederman & Menegatos, 2011), which serves as a meaningful way to connect with others and develop attachments. At the same time, sharing personal experiences with a group deepens the personal meaning and implications for the individual (Sachs, 2009), as it becomes a bridge to connect with others. Identification with role models and wanting the sobriety and clarity of others in the group serves as a motivator.

Relationship-orientated skills are practised in AA in group meetings and in one-on-one sponsorship. During meetings, emphasis is placed on newcomers learning to listen rather than speak (Arminen, 1998). Members are also discouraged from advising or addressing other participants directly in the meeting unless invited to so do (O'Halloran, 2006). Members are cautioned to share highly personal information with their sponsors rather than the group, as other members could become uncomfortable (Radasch, 1999). The focus is on learning general coping skills from each other while applying the twelve steps.

The group in the study did not have recovery sponsors, but assisted each other if it felt right and was easily accommodated by the other, and not an impingement on the person's

life. Personal boundary setting was encouraged, as was practising saying no (assertiveness) when appropriate.

The regular and consistent interaction with each other over time assisted the group participants to adapt their dysfunctional patterns of relating by observing others and cultivating new skills and relational behaviours. Qualities such as trust, respect and honesty were discussed and their application was encouraged in the group and beyond. These new behaviours are considered reparative in nature (Sachs, 2009).

3.3.1.3 Spirituality as the foundation for transformation

The influence of the spiritual component of AA, evident in its groups, has stirred much debate and interest (Ruiz et al., 2012; Tonigan et al., 2013). It has also been considered as a reason for why many do not attend AA meetings (Chassin et al., 2003; Kelly, 2017a; Tonigan et al., 2013).

However, while belief in a higher power is a key aspect of AA, the interpretation of what that higher power might be is not prescribed (Kelly, 2017a; Tonigan et al., 2013). The importance of this component is that it places something other than the addict and her substance of choice at the centre of the addict's world, and begins to widen the meaning of this world. As Young (2011, p. 214) writes, it is "the willingness to acknowledge an unseen higher power which guarantees a certain open-mindedness to consider profound identity change". For Swora (2004, p. 188), the higher power can be seen as a "field of meaning and action that is fundamentally social in nature, linguistically mediated and characterized by a manner of attending to the sacred". The spirituality of AA places emphasis on the sacred and the personal, as opposed to religious and rigid hierarchical structures (Berenson, 1990; Swora, 2004). The emphasis ideally is on a personal openness to something beyond oneself (Swora, 2004).

In short, by following the twelve steps as the backbone and curriculum of the fellowship, implemented through attending and participating in meetings, AA participants gradually change themselves and their lives. By following this programme and implementing it through their lives, personal transformation and sobriety maintenance are achieved.

3.3.2 Uptake of twelve-step programmes

It is likely that most addicts attempting recovery will attend a group at some time and, with the preponderance of the twelve-step groups, it is likely that such a group will be one of them (Marlatt & Donovan, 2005). Because these groups work on the basis of allowing participants to remain anonymous and no register is taken, statistics for attendance on a broad scale are not easy to obtain. In a 2013 American study of 3 208 participants in recovery, it was found that 95% had attended twelve-step fellowship meetings and 22% had participated in other recovery support groups (Laudet, 2013). A 2013 article in *Social Work and Public Health* reported that approximately five million people in the U.S. aged twelve and upwards participated in addiction recovery self-help groups (Donovan et al., 2013). A 2014 study found that nearly 80% of medical doctors surveyed in the U.S. referred clients to twelve-step groups; the U.S. judicial system also commonly referred those convicted of offenses involving addictive substances to a twelve-step programme (Wall et al., 2014). In a 2016 study in the U.S., 45% of recovering addicts attended twelve-step groups, 28% in combination with professional treatment and 9% using medication (Kelly et al., 2017).

Alcoholic Anonymous (AA) was founded in the U.S. in 1935 and is the largest of the mutual-aid fellowships aimed at helping alcoholics achieve sobriety and addiction recovery. In 1990 in the U.S., 22.6 million people were found to have been to AA meetings (Room, 1995). In 2001, AA reported that it had approximately two million members who gathered in 114 000 groups across 170 countries (AA, 2001). The number of AA groups has increased over the past forty years to an estimated 71 436 groups with 1 446 729 members in the U.S. and Canada, and 125 452 groups and 2 130 419 members worldwide as of January 2019 (AA, 2019). Interestingly, the number of groups has grown but not necessarily the number of members in the past 20 years.

The widespread uptake of the twelve-step model indicates that further understanding of this model of recovery would make an important contribution to the field.

In South Africa, as elsewhere, statistics on the uptake of twelve-step programmes are not easily available. AA has been running twelve-step groups since 1946 (Ruiz et al., 2012). In 2004, AA reported 314 groups across the country (Ruiz et al., 2012). By 2018 this number was reported to have increased to 376 registered groups in South Africa — which

included one group in Namibia and 12 groups in Zimbabwe, which were registered in South Africa but held in these neighbouring countries. Meetings were held in English unless otherwise indicated; literature was available in English, Afrikaans, isiZulu and isiXhosa (Mandy, 2018).

Table 3.2 Numbers of AA groups and meetings in Southern Africa in 2018, Mandy (2018)

SA province / country	No. of groups	No. of meetings per week
Gauteng	131	159 (1 held in Afrikaans)
KwaZulu-Natal	100	121 (2 held in isiZulu)
Western Cape	94	108 (1 held in isiXhosa)
Eastern Cape	28	28
Mpumalanga	6	6
Free State	5	7
Limpopo	5	5
North West	4	4
Northern Cape	3	5
SOUTH AFRICA	376	443
NAMIBIA	1	3
ZIMBABWE	12	12

Narcotics Anonymous (NA) reported having 297 groups in South Africa in 2018, with 74 in the Western Cape, 83 in Gauteng (58 in Johannesburg and 25 in Pretoria), 55 in KwaZulu-Natal, 19 in the Eastern Cape, 13 in Mpumalanga, and an additional 28 elsewhere in the country, excluding these provinces (Kaufman, 1992). There are 40 additional groups listed in sub-Saharan Africa (Mandy, 2018).

Twelve-step programmes are clearly gaining in influence as a recovery model in South Africa and elsewhere. It would appear from an Internet search that other group models (such as Smart Recovery) have a comparatively limited presence in South Africa. As the dominant model of group recovery, then, the twelve-step approach is an appropriate choice for this case study.

3.3.3 Efficacy and benefits of the twelve-step model

Ongoing participation in a twelve-step programme has been shown in numerous studies to be an effective tool for sustaining long-term abstinence as well as providing numerous other benefits (Chappel & DuPont, 1999; Emrick et al., 1993; Khantzian & Mack, 1994; Magura et al., 2013; Majer et al., 2013; Moos & Moos, 2006; Tonigan et al., 1996; Troyer et al., 1995; Zemore et al., 2013). The support provided by mutual-aid groups is particularly recommended after discharge from inpatient treatment; in fact, it has been found in short- and long-term studies to be a reliable predictor of abstinence (Kelly et al., 2006; Laudet, 2007; Morgenstern et al., 2003; Witbrodt & Kaskutas, 2005). Alcohol treatment based on the twelve-step group approach has a strong empirical basis and may even be superior to motivational enhancement and cognitive behavioural therapies, which are individual in orientation with respect to abstinence-based outcomes (Moos et al., 1999; Ouimette et al., 1998; Project MATCH Research Group, 1997, 1998b). The benefits of participating in a twelve-step group extend beyond abstinence (Humphreys et al., 2004) and include:

- Improved psychosocial functioning, including enhanced self-efficacy and assertiveness regarding relapse and motivation for abstinence (Morgenstern et al., 1997);
- Improved coping strategies (Humphreys & Moos, 2007; Humphreys et al., 1996; Moos & Timko, 2008; Morgenstern et al., 1996; Snow et al., 1994; Timko et al., 2000);
- Improved social support — particularly for recovery (Humphreys et al., 1999; Humphreys et al., 1997; Humphreys & Noke, 1997);

- Reduced psychological problems and psychiatric issues such as depression and anxiety (Cross et al., 1990; Gossop et al., 2003; Gossop et al., 2008; Kelly et al., 2010a; Wilcox et al., 2015);
- Reduced overall stress (Laudet & White, 2008);
- Increased quality of life (Gossop et al., 2003);
- Increased sense of purpose and meaning in life (Laudet et al., 2006)
- Decreased health care costs. (Humphreys & Moos, 2001); and
- The experience of mentoring others by being a role model, which enhances and motivates the recovery of the addict by validating their own sobriety while building recovery capabilities (Humphreys et al., 1999; Humphreys et al., 2004; Longabaugh et al., 2005; McKellar et al., 2003; Morgenstern et al., 1997).

Research on participation in mutual-aid groups, particularly AA, has found that it enhances recovery by promoting social groupings that affirm recovery; provides information and skills, thus building the addict's ability to cope in tricky situations and with difficult emotions, including craving and impulsivity; boosts motivation; reduces depression; and enhances psychological and spiritual well-being (U.S. Department of Health and Human Services Office of the Surgeon General, 2016). Overall, participation in recovery groups has been shown to be an effective and cost-effective resource, both during and after traditional inpatient rehabilitation.

The mechanisms responsible for the strong relationship between participation in twelve-step programmes and abstinence are not well understood, however, and further research into this area has been recommended (Allen, 2000). Researchers have studied various aspects of spirituality (Forcehimes, 2004; Sandoz, 2001; Warfield & Goldstein, 1996; Winzelberg & Humphreys, 1999), self-efficacy (Connors et al., 2001; Owen et al., 2003), coping (Humphreys et al., 1996; Longabaugh et al., 2005), and social support as some of the mechanisms of change within the groups. The positive effects of AA and other mutual-aid or twelve-step groups may not be necessarily related to their curriculum or technical nature. Rather, their strength may lie in their provision of reliable, accessible and free group recovery support (Kelly et al., 2009) with those in the same situation and further down the road. Also important is the relational fit between the participant and the social learning context of the particular group.

3.3.3.1 The role of relationship in recovery

Social support is often regarded by treatment professionals as a key benefit of self-help recovery groups (Woff et al., 1996). Moos (2008) identified the following group aspects as being positively linked with long-term sobriety from various substances: bonding and support; obtaining an abstinence-focused role model; and doing service work within the groups (Moos, 2008). A review of 24 studies examining the advantages of participation in AA membership found similar results (Groh et al., 2008).

Using four different theoretical lenses, Moos (2008) suggests the following curative factors:

- Social control theory highlights factors such as bonding, goal direction and structure;
- Social learning theory specifies the importance of norms and role models;
- Behavioural economics and behavioural choice theory highlights participation in alternative and pleasurable activities; and
- Stress and coping theory highlights building self-efficacy and useful and appropriate life-skills.

Making sober friends

Project MATCH, an eight-year, multi-site study involving 1 726 participants, which began in 1989 in the U.S., matched the characteristics of alcoholics with the forms of treatment that were found to be most effective for them (Connors, Tonigan, et al., 2001). One of the findings was that the group provided participants with opportunities to make new friends who were not using the substance of choice, which supported them in avoiding friends who were users (Connors, Tonigan, et al., 2001; Kelly et al., 2012). Other studies bear out the importance of developing networks of those who are sober, given that the social bonds in recovery networks tend to be stronger, and the quality of friendships better, than in groupings of those who bond over substances (Humphreys et al., 2004). The benefits of having social groups of those who are sober have been shown to reduce the stigma of addiction and the recovery process through their support (Bliuc et al., 2019). In contrast, maintaining links with one's previous networks of friends who are still

involved in addiction is understandably associated with relapse and poorer outcomes following treatment (Dingle et al., 2015; Havassy et al., 1991).

Exposure to role models

Participation in twelve-step groups exposes participants to peers who face the common challenge of remaining substance-free. In this way, the group provides role models with whom new participants can identify. These 'old-timers' provide living proof that recovery is achievable, share tools to manage relapse triggers and emotions, and provide support on a regular basis, including spiritual support for those members for whom this is important (AA, 2001; Humphreys et al., 1999; Humphreys, Mankowski, et al., 1999; Humphreys & Noke, 1997; Humphreys et al., 2004; Laudet et al., 2003; McCrady & Miller, 1993).

Identity change and identification with others are significant aspects of recovery — in Project MATCH, self-identification as an AA member, attendance, and number of steps completed were closely associated with abstinence (Cloud et al., 2004; Granfield & Cloud, 2001). These concepts are more thoroughly discussed in the present study in the theoretical framework and findings chapters.

Induction into an altruistic way of life

AA has been found to embody certain aspects that are typical of religious groups, social networks and charities. For instance, members often remain in the organisation many years into their recoveries, using AA as a lifestyle and opportunity to assist others (Groh et al., 2008; Humphreys, Mankowski, et al., 1999; Humphreys et al., 1997). While addiction results in a self-absorbed way of life, as will be seen in the findings of this study, twelve-step groups model an altruistic way of life based on supporting others, which turns the addict toward a new way of living that supports recovery.

3.3.3.2 The role of group attendance in recovery

Research has shown that recovery is well supported via mutual-aid participation (Dennis et al., 2005; Laudet et al., 2002). Studies have found that regular AA attendance is associated with higher short-term alcohol-related outcomes than infrequent or irregular attendance; in addition, ongoing AA participation resulted in reduction of substance use disorder criteria (Connors, Donovan, et al., 2001; Tonigan et al., 2000; Tonigan et al., 2003). Other studies found that among active, long-term members of AA, 40–50% had been abstinent for several years, while 60–68% cut down their drinking; compared to alcoholics who had received treatment from professionals, AA members had higher sobriety outcomes (Emrick, 1987; Emrick & Tonigan, 2004).

Correlation of frequent attendance with sustained recovery

Attending meetings at least weekly has been positively correlated with drug and alcohol abstinence; less than weekly participation is negatively correlated with drug and alcohol abstinence (Giacomini & Cook, 2000). Project MATCH found that those who attended AA more often in the first three months post-discharge from rehab were more likely to maintain sobriety during that time (Kelly et al., 2009). They also found that the more frequent the AA attendance was during those three months, the greater the likelihood of abstinence (Emrick & Tonigan, 2004; Owen et al., 2003; Tonigan et al., 2003). This held true for patients from all three types of groups studied: AA, cognitive-behavioural and motivational enhancement. A reduction in alcohol consumption and an increase in abstinent days at a six-month follow up was found in those who attended AA meetings at least weekly (Gossop et al., 2008), compared with those who attended less frequently or not at all. It was also found that those who participated in AA for the first two years of their recovery, attending twice a week or more, were more likely to be abstinent in the second and subsequent years of their recovery (Kelly et al., 2006). In one study, occasional and moderate twelve-step attendance and participation resulted in significantly better drinking outcomes than non-attendance; an increase in frequent attendance, however, was not associated with significantly better outcomes (Connors, Donovan, et al., 2001).

Correlation of long-term attendance with sustained recovery

Studies have found that the length of time of group attendance is more strongly related to substance use outcomes than the frequency of attendance (Moos & Timko, 2008) at the five-year mark (Morgenstern et al., 1997). In numerous studies, participation in a twelve-step group was found to contribute to sustained recovery in studies during the first three years (Kaskutas et al., 2014; Witbrodt & Kaskutas, 2005), five years (Gossop et al., 2008) and ten years of abstinence (Hoffmann & Miller, 1993). This was also found in research on abstinence from drugs and alcohol at six and twenty-four months into recovery (Fiorentine, 2000; Kissin et al., 2003). In one study, patients who received twelve-step or formal treatment or both were more likely to be abstinent at the eight-year mark than those who were untreated. Patients who only attended twelve-step programmes during their first year of recovery still maintained better drinking outcomes at the eight-year mark than those who had not attended at all (Connors, Donovan, et al., 2001). Similar results were seen in other self-help programmes such as Narcotics Anonymous (NA), where meeting attendance in the first year was correlated with significantly decreased use of marijuana (Toumbourou et al., 2002).

In short, attending over the long term leads to better abstinence outcomes than attending as many meetings as possible. In fact, many recovered addicts eventually leave the group, confident in their sobriety, but choose to return from time to time if they are going through a difficult time, or for a sober anniversary among those who understand; having access to a group as a lifelong resource, whether one attends regularly or not, is thus a stabilising and containing factor in recovery (Flores, 2013).

Correlation between severity of addiction and attendance

Studies have found that those with longer-term addictions (Kelly et al., 2006) and more severe addictions had a positive association with regular attendance of twelve-step groups post inpatient discharge (Connors, Tonigan, et al., 2001; Kissin et al., 2003). Other studies have reported similar findings (Brown et al., 2001; McKay et al., 1998).

One study involving a large sample of adults admitted for government-funded addiction inpatient treatment reported longer stays and more severe addictions (Kissin et al., 2003).

This was similar to another study which found that those who attended just over one meeting a day had histories of severe addiction, compared with those who attended under half a meeting a day and those who did not attend meetings at all (Brown et al., 2001). The effectiveness of twelve-step participation has also been shown to increase with addiction severity; regular participants also reported a greater number of incarcerations and inpatient rehabilitations as well as an earlier age of usage of alcohol (Montgomery et al., 1995).

Demographic factors correlated with attendance

Women have been found to be willing to attend and participate in groups more often than men, with outcomes as good as or better than for men (Kaskutas, 1994; Kaskutas et al., 2005). Moos and Moos (2006) found that the positive association between a longer duration of AA attendance and a stable recovery trajectory was stronger for women. For older adults (above 55), group attendance and abstinence outcomes were good (Lemke & Moos, 2003) and they showed a better than expected response to inpatient treatment, with gains in all the areas of treatment (McLellan & Meyers, 2004). A twenty-year follow up study showed that older adults who attend AA do reduce their intake and alcohol-related problems (Brennan, Schutte, Moos, & Moos, 2011)

Satre et al. (2004) found that the participation of older people was the same as that of younger people. Their research indicated a reluctance on the part of older people to participate in twelve-step groups, but once they get there, they did better than other age groups (Satre et al., 2004). The participants in the group in this study were mostly older people, so this point is salient and indeed supports these findings.

A strong link has been found between twelve-step attendance and abstinence among those who are younger, white, not highly educated, irregularly employed, not particularly religious and with poor relationship skills — in other words, those who would benefit greatly from the various resources offered through twelve-step participation personally and to support their recoveries (Timko et al., 2006).

3.3.4 Critique of the twelve-step model

Research has been conducted on AA and other twelve-step groups for over fifty years (Kurtz, 2008, p. 1). Various criticisms have been levelled at the twelve-step model by researchers. Some have criticised the model for the difficulty of evaluating its efficacy due to its lack of record keeping for purposes of confidentiality (Snow et al., 1994). Others have criticised the model for its spiritual focus (Bufe, 1997; Chappel, 1992; Schaler, 2000), expressing frustration with AA's spiritual, and seemingly unmeasurable, approach (Swora, 2004). Swora (2004, p. 190) called the model "coercive, pietistic and even cultic".

Criticism of the spiritual aspects of the twelve-step model has focused on four common arguments, as follows (Dossett, 2013):

1) The model is a front for religion.
2) The model is inherently sexist.
3) The model excludes, to a large degree, non-Judeo-Christian or post-Christian world-views.
4) The model's approach of formulating addiction as a 'spiritual illness with a spiritual solution' increasingly stigmatises the addict and perpetuates a sense of powerlessness — that one could never escape addiction on one's own.

It has been considered by the author that those not willing or able to embrace recovery, for whatever reason, will find reasons to criticise the programme, with spirituality being at the forefront of the attack. Having said this, all groups are run differently depending on their leadership and it may be that groups have earned themselves the reputation of being 'cults' through their approach.

Criticisms related to the way in which the model obstructs the measurement of results have focused on its policies of anonymity (Kelly et al., 2002; Kelly et al., 2006), its lack of professional facilitators, its practice of not collecting information on either its members or its efficacy, and its conception of recovery being a lifelong process, with no clear end-point (Wallace, 1996). There have also been complaints about twelve-step programmes' unwillingness to engage with researchers (McAdams, 2013).

There has also been criticism of the research conducted on this model. Critique has focused on how some studies lacked prospective designs, used samples which were homogenous and lacked diversity or a control, did not use previously validated measures, did not control for potential confounding variables, and were unable to accurately measure direct cause-and-effect (Tonigan et al., 1996).

Ferri et al.'s (2006) hard-hitting conclusion in a 2006 meta-analysis involving eight trials and 3 417 people, published in the *Cochrane Review*, reads: "No experimental studies unequivocally demonstrated the effectiveness of AA or TSF [Twelve-Step Facilitation] approaches for reducing alcohol dependence or problems" (Ferri et al., 2006, p. 2). They criticised previous research by saying "there were some limitations with these studies. Furthermore, many different interventions were often compared in the same study and too many hypotheses were tested at the same time to identify factors which determine treatment success" (Ferri et al., 2006, p. 2). They also stated that "it should also be underlined that in the available studies all the interventions appeared to improve at least some of the outcomes considered" (Ferri et al., 2006, p. 8).

In response to the Cochrane findings, Kaskutas (2009) strongly urged that readers make their own interpretation of what she cited as evidence for AA effectiveness. She stated that abstinence rates are approximately twice as high among those who attend AA, that more attendance of meetings leads to higher rates of abstinence, and that this was found for these different samples and follow-up periods. In later work, Kaskutas et al. (2014) showed that prior AA attendance is predictive of subsequent abstinence, and that mechanisms of action predicted by theories of behaviour change are seen at AA meetings and through the AA steps and fellowship (Kaskutas et al., 2014).

This study hopes to contribute an understanding of the mechanisms in a working recovery group, regardless of its approach. These critiques do not pose a problem to this study: that much of the research has found a positive correlation between group participation and recovery emphasises the importance of human relationship in recovery and highlights the need for a better understanding of the mechanisms that operate in recovery groups which facilitate transformation for the addict — the focus of this study.

3.3.5 Adaptation of the twelve-step model for specific groups

While the twelve-step model was developed specifically to address addiction, the non-judgemental connection with others which it encourages is also beneficial to people who are marginalised by society. Twelve-step groups have thus emerged that are specific to under-represented groups, including women; lesbian, gay, bisexual, and transgender (LGBT) populations; African Americans; youth; and other groupings (USSAMHS, 2016). Some studies have focused on how people from different cultural backgrounds have adapted the twelve-step model to meet their needs (Denisco et al., 2008; Myers & Parry, 2005; Sawyer et al., 2006; Sorsdahl et al., 2012; White, 2008a). For example, these studies have researched recovery via this model among the indigenous peoples of Australia, New Zealand, Canada and the U.S., and the online AA communities in Russia and Poland as well as Hispanic populations within the U.S. American Indian and Alaskan Native groups have adapted AA to make the groups more welcoming to their cultures in terms of spirituality and the procedures, by allowing families to attend, speaking their indigenous languages, as well as not limiting the groups by time, but giving everyone an opportunity to speak (USSAMHS, 2016). The adaptability of the twelve-step model, combined with its easy accessibility — groups are free of charge, anonymous and require no paperwork or insurance company documentation — illuminates why these groups appeal to such a diverse range of people (Timko, 2008).

This section has shown that numerous clinical trials have demonstrated that long-term, frequent participation in recovery groups increases the chances for sustained remission and recovery. It is thus critical that health-care professionals encourage their patients to join these groups. However, most government facilities and clinic programmes do not offer these services. The group which is the focus of this research study was located at the same clinic where the participants had undergone inpatient rehabilitation; the clinic thus provided continuity of care by facilitating long-term recovery groups.

3.4 THE PSYCHOLOGICAL GROUP WORK MODEL

Group therapy is based on the supposition that the heart of being human is social as opposed to individual (Reading, B., & Weegmann, M. 2008, p2). This dovetails neatly with the thinking embodied in the previous section on the twelve-step model as well as

with social learning theory and communities of practice theory, which are discussed in the following chapter. The case can be made that when an addict repeatedly turns to an addictive substance in an attempt to manage his emotions, he effectively has a relationship with the substance. In group therapy, the dictum "the opposite of addiction is human connection" (Hari, 2015) resonates with Khantzian's observation that "suffering is at the core of addictive vulnerability … the worst fate, however, is not just to suffer, but to suffer alone" (Khantzian, 2001, p. 19).

The context of a therapeutic group facilitates the social learning of and transformation of an addict in recovery (Brown & Yalom, 1977; Flores, 1997; Khantzian & Mack, 1994; Vannicelli, 1992). Psychodynamic group work expert Caroline Garland argues that learning is most effective when it takes place within one's experience (Garland, 2010).

Garland (2010) suggests that when the group participant shares the space with others experiencing similar things, it overcomes their feelings of loneliness, shame, guilt, frustration and suffering. A shared sense of vulnerability, acceptance and identification brings relief, comfort and a feeling of being positive and hopeful. These foster experiences of not feeling like an outsider or so alone, and a sense of connection and the beginning of membership. This has links with communities of practice theory which is discussed in detail in Chapter 4.

Ideally, the group should establish a climate of "optimal frustration" (Flores, 2001, p67) — where just enough of the addicts' dependency needs are met until they are able to internalise emotional regulation, where the facilitator is intentionally more gratifying than with other groups. The strong holding environment of the group (strengthened by rules, rituals, routines, awareness of curative factors and trust in fellow participants and facilitators) is essential for participants to feel safe, accepted and contained sufficiently to do the work of recovery. Höfler and Kooyman (1996, p. 517) note that group work meets "the struggling individual where she suffers the most: in the nonverbal need of a reliable holding relationship".

Participating in a group affords participants not only the opportunity to participate in their own healing journey, but also those of others. The experience of helping another person can help to rekindle a sense of meaning in a participant's life. Over time, the reciprocity

experienced in the group can help participants cultivate a formerly derelicted empathy and develop the ability to see others as separate from themselves.

3.4.1 Yalom's curative factors of group work in addiction recovery

Irvin Yalom, a pioneer in the area of existential psychotherapy and an expert on group work, has done extensive work exploring the variables within a therapeutic group which contribute to the transformation of its members (Forester-Miller, 1989).

Yalom has proposed that group work produces particular therapeutic, or curative factors, such as cohesiveness, support and belonging, which are "the actual mechanisms of effecting change in the patient" (Yalom, 1975, p. xi). He sees the engine of change within the group as the interaction between the members themselves, the task of the facilitator being to mindfully foster this (Yalom, 1975). This underscores the social learning aspects of the group.

As the psychologist co-facilitating the group in this study, it was essential to attentively nurture these conditions within the group remembering that, as an addiction recovery group, participants ranged from inpatients of the clinic's rehabilitation programme who were still in the detoxing phase to those who had completed their inpatient treatment and were outpatients, in recovery. It was also important to be sensitive to issues around language, gender and culture in terms of how they might affect members' participation and sense of belonging.

Yalom (1975) identifies the following eleven curative factors as influencing personal change in the participants of group. Examples from the group are given, not as research data but as part of the bricolage tradition, to elaborate on the curative factors.

1. The instillation of hope creates a feeling of optimism. An addict needs to hold onto the fact that choosing a sober life is choosing a better life, because it is a challenging journey. Interaction with recovering addicts who are further along in this journey and with whom the participant can identify helps to instil hope. The knowledge, experience and enthusiasm of the facilitators and 'old-timers' in the group also generate inspiration and encouragement in newcomers. Observing change in oneself and others provides the hope and motivation to continue.

2. Universality refers to the realisation that others have needs, impulses and issues similar to one's own, which helps to overcome the addict's sense of isolation and loneliness. It can bring great relief to an addict to realise that emotions which can seem unbearable, such as shame, are common among those who have experienced addiction. This was cited as the most important benefit of group work for a group of sex addicts, for whom an unbearable sense of loneliness contributed to their addiction (Nerenberg, 2000).

In the context of the group in this study, I found that universality occurred naturally in the group process. I was mindful to underscore it when it happened.

3. Imparting information empowers addicts with a deeper understanding of their addiction, which can help them to deal with the stigma associated with their disease. Twelve-step programmes typically make use of practical aphorisms such as "one drink is too many and a thousand is never enough" which has compacted a lot of information into a catchy slogan.

As the psychologist in the group, I explained how the group works to support its recovering participants and educated the members about group processes. The addiction counsellors used aphorisms commonly which they had learned through twelve-step group participation during their own recoveries.

4. Altruism refers to members of the group helping each other during a group session, which contributes to participants' sense of purpose, builds their self-esteem and helps individual participants and the group gain perspective on how far they have come in their recoveries. Like Yalom, Adler believes that to participate in "interpersonal interaction [is] to develop the feeling of being part of a larger social community" (Mosak, 2000). Adler suggests this to be the most important of all social attitudes, as it inhibits egocentrism while promoting social interest (Borden, 2000; Mosak, 2000). The opportunity to assist others thus provides a significant motivation to participants to return to a group while also representing an important aspect of social learning.

5. Corrective recapitulation refers to the resolution of family and childhood issues, such as difficulty with authority/parental figures, trauma in the family, issues with peers or siblings, and issues such as intimacy, hostility and competitiveness, within the safety of the group, which is conceptualised as a 'family'. The therapist and other participants can provide corrective emotional figures or experiences.

In the context of this study, many of the participants referred to the group as their 'family' repeatedly. While this was not a focus of my work with the group in the study, I took note of this phenomenon. For example, participants often referred to the other group members as the family they chose. Another example was that one of the participants who had linked the onset of his drinking to the traumatic loss of his brother was able to commit his recovery to living — instead of dying — for his brother.

6. Socialising techniques, for Yalom (2005), such as respect for others, empathy, tolerance and other interpersonal skills, are fundamental to social development. Many people with addiction suffer from social anxiety (Caplan, 2006; Lee et al., 2001; Weinstein et al., 2015) and report that they are unable to socialise without first using a substance or socialising online (Ferri et al., 2006). Twelve-step programmes have long recognised the importance of breaking the isolation associated with substance abuse, while at the same time connecting individuals with others in recovery (CSAT, 1994).

In this study, group participants were offered tea and coffee after the group, which provided an opportunity to socialise and develop these skills. A few participants commented on this positively during the data-gathering process.

7. **Imitative behaviour**: In group work, participants often imitate the behaviour of facilitators and other group members in order to learn their coping strategies and perspectives and make them their own. Trying others' approaches and seeing if they work helps participants better understand themselves and also promotes the development of their socialising techniques.

8. Interpersonal learning focuses on the development of supportive relationships. This aspect of social learning through observation, participation and feedback is vital. The participant gets to know others through honest interaction and builds up trust in the context of a non-threatening and moderated environment. This is vital to the addict whose life has typically been characterised by chaos and deception before entering treatment.

Another outcome of group psychotherapy pertinent to this study is the ability to develop relationships with others (Hook et al., 2008). A distinct group culture emerges, different from the culture of other groups, in which the various group members develop new ways of belonging and relating to each other, and new coping skills relevant to the practice at hand (Line & Cooper, 2002). This fits with the communities of practice model, which

also emphasises the various aspects of belonging and identity. This is discussed in detail in Chapter 4 (Theoretical Framework) and Chapter 13 (From Competency Framework to Regime of Competence).

9. Group cohesiveness is not directly defined by Yalom, even though he considered it to be the most powerful factor in group work (Marmarosh et al., 2005). It is because of the cohesion of the group that participants engage in self-disclosure and personal exploration of difficult issues. He argues that it facilitates greater collective self-esteem, generates well-being and provides the vital context in which treatment occurs. The importance of cohesiveness has been observed across cultures and addictions (Ahmed et al., 2010; Nerenberg, 2000). Group cohesiveness gives members a sense of acceptance, belonging, purpose, and security, and of being valued by each other and valuing the group, in turn (Marmarosh et al., 2005). The perceived cohesiveness of AA groups has been found to be predictive of abstinence beyond meeting attendance (Rice & Tonigan, 2012) Thus, group work helps people in recovery replace addictions and unhealthy attachments with supportive relationships, which is key to recovery (Flores, 2013).

This factor works well with communities of practice theory's aspects around membership. In one study of an AA group it was found that group cohesion "predicted increased AA meeting attendance … [which] significantly predicted subsequent abstinence" (Rice & Tonigan, 2012, pp. 47–48).

Cohesiveness was observed in the group work in this study in the form of mutual teasing, referring with kindness and concern to personal aspects of each other's lives, and a feeling of warmth in the room, despite and because of the challenges of the work of recovery.

10. Catharsis refers to the release of suppressed emotions that promotes healing. Catharsis can bring great relief not only to the person experiencing it but also to those witnessing it, who often experience compassion for and closeness to the person who is experiencing catharsis, and often relate the material to issues and experiences in their own lives. In a study in 2010, catharsis was found to be the most important curative factor in group work, followed by group cohesiveness (Ahmed et al., 2010).

An example of catharsis during group work in this study was when one of the participants wept as she admitted her inability to save her mother from her addiction, even though she was managing to save herself from hers.

11. Existential factors refers to those 'givens' that make up life — such as pain, death, sadness, regret and joy — and the need to embrace these aspects of life with acceptance, understanding that they enrich our lives, rather than trying to escape from them.

There was place for — and voice given — to all such aspects of the human experience in the group.

3.4.2 Some research findings on various curative factors

Addicts who have participated in group work have a significantly more favourable outcome rate than those who received other modes of treatment (Ahmed et al., 2010). In one study, participants ranked catharsis as the factor that contributed most significantly to their recovery, followed by group cohesiveness and interpersonal learning (Ahmed et al., 2010). In another study, installation of hope and universality were found to play a key role in preventing relapse among alcoholics (Demirbas et al., 2012). Interpersonal learning was found to be advantageous in group therapy (Yalom, 2005), while the importance of universality, altruism, socialising techniques, imparting of information and the installation of hope have been found to be important in twelve-step groups (Shelley & Santiago, 2013). Yalom and Terra (Terra et al., 2008) interviewed 300 alcoholic patients at three and six months into recovery in Brazil and found that the instillation of hope and universality are essential therapeutic factors in alcoholic patient groups.

For me, as the psychologist in the group, working mindfully and pedagogically with these factors and applying them to the addiction recovery group generated a fuller understanding of the social learning that occurred in the group.

3.5 OTHER GROUP APPROACHES TO RECOVERY

While this chapter deals exclusively with the twelve-step model which is the focus of this study, one might assume that any programme based on a fellowship that offers social support, a sense of belonging and a curriculum of competencies to support recovery would be similarly successful. Little research has been done on other models; however, the research that does exist supports this. Rational Recovery is a self-help approach to

recovery which was pioneered by a clinical social worker in 1986. It teaches cognitive skills and has met with positive results (Galanter et al., 1993). Results from research done on the addiction recovery programmes Women for Sobriety, LifeRing, and SMART found them to be as effective as twelve-step groups, and that this population (women) has the best odds of success when committing to lifetime total abstinence (Zemore et al., 2018). An optimal care plan may thus involve facilitating involvement in a broad array of mutual-aid groups and supporting abstinence motivation (Zemore et al., 2017; Zemore et al., 2018) or, alternatively, finding a group where one feels the most comfortable.

3.6 THE ROLE OF THIS STUDY IN ADDRESSING THE GAP IN RESEARCH ON THE MECHANISMS OF GROUP RECOVERY

While a large body of research has demonstrated that group work plays a key role in recovery, the mechanisms in the group that support recovery are not well understood.

Despite this, after a large amount of research had been conducted on twelve-step groups — and recovery groups, in general — between 1990 and 2010, interest in studying the group model for recovery appears to have waned. This is puzzling, given that drug and alcohol addiction is on the rise globally and that group programmes — the most popular treatment mode — have proven both effective and affordable. Perhaps researchers feel they have exhausted the aspects that merit study or, as addiction expert Martin Weegmann suggested in a personal communication to me, they feel "somehow the research seems to have had its heyday" (M. Weegmann, personal communication, March 9, 2018). In addition, studies which focus on abstinence over a defined period of time have easily defined outcomes — the participant either abstains or she does not — while it becomes more difficult to measure outcomes when studying the broader and more complex nature of personal transformation over time.

My hope is that this study will rekindle interest in research into the recovery group model. The interdisciplinary approach taken in this study, which draws on social learning theory and addiction theory from the disciplines of education and psychology, has not been used before in the study of addiction recovery groups. It thus contributes a new depth of multidisciplinary understanding to the personal transformation of the group members as

well as a new breadth of understanding regarding the group mechanisms that facilitate this ongoing transformation in addiction recovery.

In addition, there has also been little research conducted on group recovery in South Africa (while there has been, and is, ongoing work on addiction). This study contributes to the research on addiction and recovery in South Africa. It also contributes to the field of education by unpacking the pedagogy of group recovery.

3.7 CONCLUSION

This chapter has provided a research-oriented overview of the group recovery approach, focusing specifically on the twelve-step recovery group and psychotherapy group models which informed the design of the recovery group that was the focus of this study. While this research has identified key aspects of the twelve-step and therapeutic group work approaches which aid recovery, the group mechanisms that facilitate personal transformation from addiction to sustained recovery are not well understood; this study seeks to contribute new knowledge in this area.

The following chapter will explore the theoretical framework that is relevant to the study of group mechanisms that support the transformation of members of the group — specifically, communities of practice theory as well as psychodynamic and psychoanalytic approaches to addiction and recovery.

CHAPTER 4
THEORETICAL FRAMEWORK

4.1 INTRODUCTION

The previous chapters have introduced the topic of group recovery mechanisms by focusing on elements of the recovery group itself. In particular, the benefits of transformation through various aspects of participation, which happen in a recovery group, were unpacked.

This chapter deepens the examination of the critical aspect of relationship within the group, looking firstly at social learning, especially through the communities of practice lens, and then surveying psychodynamic explanations of addiction, in which it is hypothesised that in the addict's original identity formation in relationship, the ground for addiction is laid. The theories work harmoniously together, and do not "step on each other's toes, but climb on each other's shoulders" (Wenger-Trayner, 2013, p. 109) as social theories should. The notion of identity is central to both theories and will be applied to the identity transformation of the addict in the recovery group, thereby showing group dynamics and individual transformation in the service of addiction recovery.

4.2 COMMUNITIES OF PRACTICE

Social learning — how addicts learn to recover in a social context — is one of the central aspects of this study. Communities of practice is the social learning theory which best relates to the topic of this study. Wenger (2010) describes it as

> a perspective that locates learning not in the head or outside it, but in the relationship between the person and the world, which for human beings is a social person in a social world. In this relation of participation, the social and the individual constitute each other. (p. 1)

Anthropologist Jean Lave, one of the pioneers of community of practice theory, asks the insightful question, so relevant to this study because of its accepting and human approach,

"Why pursue a social rather than a more familiar psychological theory of learning?" to which she offers the response that

> to the extent that being human is a relational matter, generated in social living, historically, in social formations whose participants engage with each other as a condition and precondition for their existence, theories that conceive of learning as a special universal mental process impoverish and misrecognize it. (Lave, 1996, p. 149)

Lave's view that social learning is essential to being human resonated with the approach of this study.

Lave (1996) argued that focusing on a social justice aspect that reduces learning to individual cognition as a conclusion ultimately blames marginalised people for being marginal; it is vital to explore ways of understanding learning that do not normalise — and implicitly support — social divisions which promote inequality. A social learning theory is thus well suited to a study focused on the recovery population, since addiction cuts across social class, race, gender, sexuality, geography and culture. In addition, as addiction carries a stigma in our society, reconsidering learning as a social, and collective phenomenon — as opposed to solely an individual, psychological phenomenon — does greater justice to the human learning experience.

The following sections contextualise communities of practice theory within social learning theory, unpack key aspects of communities of practice theory and look at the applications — including in the twelve-step tradition — as well as the criticisms of the theory.

4.2.1 Communities of practice in the context of social learning theory

McDermott's description of social learning makes it clear why this theoretical lens is so appropriate to group recovery from addiction:

> Learning is in the relationships between people. … Learning is in the conditions that bring people together and organize a point of contact that allows for particular pieces of information to take on a relevance. Without the points of contact, without

> the system of relevancies, there is not learning, and there is little memory. Learning does not belong to individual persons, but to the various conversations of which they are a part. (in Murphy, 1999, p. 17)

This understanding of social learning is useful for highlighting some of the key aspects of group recovery. These include having a common reason to be together, a shared understanding of belonging and membership, and a common meeting place where a consensual and a definite practice can occur, and core knowledge can be transmitted through joint participation that is held to be important because of shared meanings and understanding.

The concept of social learning has been historically tricky to pin down. Early pioneers defined social learning as individual learning that occurs in a social context and is thus affected by social norms and mores (Bandura, 1997, in Reed et al., 2010). However, this conceptualisation is too vague as it can refer to almost all of the learning that occurs in any social environment. A more activist approach conceives of social learning as a process in which people learn from each other in ways that can benefit wider social systems (Fairbairn, 1943; Khantzian, 1975; Lave, 1996; Panel, 2007; Reed et al., 2010; Spooner, 2012; White, 1998); given that about half the adults in the U.S. have a close friend or family member affected by addiction, the potential for benefits to those in the lives of addicts learning in recovery is evident (Cloninger, 1987).

Another approach sees social learning as occurring through social interaction and/or facilitative mechanisms (Reed et al., 2010). This brings us closer to the workings of the addiction recovery group, which uses both social interaction and the facilitative mechanisms that are explored later in this chapter.

For Reed et al. (2010), social learning requires the following conditions to occur:

i. Where a change in understanding has occurred (this may be at a surface level, e.g. information, or deeper levels, such as identity (re)construction);
ii. A focus on learning that is situated in a community of practice, or wider social units (hence learning has gone beyond the individual);
iii. Where participants learn through social engagement with each other.

This brings us nearer to what we need to account for how addicts learn to recover in a group, and is useful, as the evidence of this learning could therefore be observed in various ways.

An example of the second criterion focuses on how social units learn (as opposed to individuals): an example is Freire's concept of *conscientizacao*, in which people can become critically literate and conscientised about their situations via collective reflection and problematisation (Woicik et al., 2009). The Gestalt perspective that the whole is greater than the sum of its parts is evident in Janis's (1989, in Reed et al., 2010) Groupthink work, where collective learning outstripped individual learning.

Because of this potential, and social application, this approach has been used in adult education in peace studies and citizenship studies, demonstrating how these qualities are best learnt through experiences of active involvement and participation rather than individually from a formal curriculum (Akhtar, 2018; Reed et al., 2010; Thomas, 2017). The learning from one's own direct experience is at the heart of the group work that is the topic of this study.

This highlights the importance of creating optimal conditions conducive to participants being able to link experiences, reflection and experimentation in order to facilitate learning (Kolb, 1984, in Reed et al., 2010). These 'optimal conditions' will be explored in this study in part by looking at the various mechanisms and conditions that exist in the recovery group and how these facilitate the learning and maintenance of addiction recovery.

The third criterion of social learning — learning through engaging with others — is the mode through which the learning occurs. In other words, the message is spread from person to person via a social aggregation of participants (group, social network, practice, etc.). Here the relationships between participants or members of a particular social unit are considered key to the learning — and this would include being impacted by power and trust relationships and individual dynamics as well. The quality of the relationship, brought about by a mutual fit between participants (including qualities such as trust, commonality, acceptance, respect and ability to get on with the other), is vital and is likely to play a part in mutual support for participants between sessions in the addiction recovery group. This element is pivotal to social learning and is clearly essential in the relationships

among members of a recovery support group, who place their vulnerable, newly recovering selves in each other's hands.

Broadly speaking, then, social learning can be defined as "a change in understanding that goes beyond the individual to become situated within wider social units or communities of practice through social interactions between actors within social networks" (Reed et al., 2010, p. 1).

Social learning, from a communities of practice viewpoint, involves active participation in the practices of a community (Lave & Wenger, 1991; Wenger, 1998b) — of which the addiction recovery group and practice is an example — where the focus is also placed on meaning and identity construction. This is elaborated on by Wenger (1998b), who considers changes in meaning and identity construction of the participant(s) to be an indicator of social learning. These aspects are closely explored in this study.

Because of this, Lave and Wenger's theoretical lens (1991, 1998) will be used as a way of assisting understanding of and focusing on the phenomenon more accurately. Wenger has referred to a community of practice as a parallel universe that non-members of that universe are unable to know or see. In summary, learning is an experience of particular and relevant meaning through performing a particular practice which allows its participants to interpret the world in new ways through being initiated into the specific practice. In this way, too, learning in the context of a communities of practice model is dynamic, and interactional — where experience enriches practice and practice deepens and defines experience.

For Lave and Wenger, learning is situated in social relationships and settings, and is not seen as the gaining of certain types of knowledge (Lave & Wenger, 1991). For them, it is important that learners actively participate in social structures and arrangements that facilitate this learning. The term 'participation' refers "not just to local events of engagement in certain activities with certain people, but to a more encompassing process of being active participants in the practices of social communities and constructing identities in relation to these communities" (Wenger, 1998b, p. 4). Lave and Wenger have termed the reciprocal interrelationship between both participation and practice "mutually constitutive" (Lave & Wenger, 1991, pp. 51–52). The individual enacts and forms the community, which in turn is enacted and forms and changes the individual participant.

These communities are termed ‘enacted’ when their members carry out their roles from the community as they go about their daily lives (Tsoukas & Chia, 2002).

The notion of participation is central to the communities of practice approach, as was seen when examining findings on the efficacy of twelve-step groups and the maintenance of abstinence, in the previous chapter. Participation is seen as the basic process by which participants learn and become through the practice.

4.2.2 The development of communities of practice theory

The term ‘communities of practice’ originated from the work of Lave and Wenger (1991) in the Work Practice and Technology group at the Institute for Research on Learning (IRL) at the Xerox Palo Alto Research Centre (PARC) in the late 1980s. Here specialists from various disciplines, including Jean Lave, Etienne Wenger, John Seely Brown and Paul Duguid, were brought together into an academic ‘melting pot’ (Kimble, 2006). At the time, Wenger was Lave’s student.

In 1991, Lave and Wenger introduced the concept of ‘communities of practice’ in their seminal work, *Situated learning: Legitimate peripheral participation*.

The original notion of communities of practice has continued to grow in complexity and breadth since its inception in 1991. While there are countless references to the term ‘community’, only a few theoretically sound definitions have been developed which to grasp the complexity of group learning. These include:

> Communities of practice are groups of people who share expertise and passion about a topic and interact on an ongoing basis to further their learning in this domain. (Wenger et al., 2002, p. 4)

> A community of practice is a group of people who share an interest in a domain of human endeavour and engage in a process of collective learning that creates bonds between them: a tribe, a garage band, a group of engineers working on similar problems. (Wenger, 2001, p. 2)

> A community of practice is a group of people who interact, learn together, build relationships, and in the process develop a sense of belonging and mutual commitment. Having others who share your general perception of the domain and yet bring their individual perspectives on any given problem creates a social learning system that goes beyond the sum of its parts. (Wenger et al., 2002, p. 34)

The addiction recovery group is an ideal example of the third instance mentioned above.

Wenger et al. (2011) defined communities of practice as a "learning partnership among people who find it useful to learn from and with each other about a particular domain. They use each other's experience of practice as a learning resource" (p. 9).

All of the above definitions can be applied to the recovery practice, which is the focus of this study.

4.2.3 Elements of communities of practice theory

This theoretical lens of communities of practice, with its various technical terms (newcomer and old-timer, apprenticeship, membership, identity, regime/repertoire of practice, amongst others) and technical conceptualisations, provides tools to describe group processes and ultimately speaks to the central notion of the learner's identity. When viewed from a communities of practice perspective, taking identity to be an organising principle, this theoretical lens assists in focusing on understanding the various types of learning contexts that promote identity negotiation (Farnsworth et al., 2016), and hence speaks to various mechanisms within the addiction recovery group that facilitate and maintain the identity transformation of its participants.

Some of the following technical terms have evolved as the communities of practice theory has developed; in this study they are used as explained in Lave and Wenger's (1991) and Wenger's (1998) work.

4.2.3.1 Situated learning

The term 'communities of practice' was initially used to describe situated learning (Lave & Wenger, 1991). Situated learning involves the acquisition of knowledge through various types of social engagement and participation in a specifically constructed context, embedded within both a physical location and a social environment. The learning that occurs here is highly interactive, with the participant learner not simply accessing a static body of abstract theory to be transplanted to subsequent situations and contexts, but learning by engaging in the practice itself within a participatory framework. This approach to learning uses informal, situated social interaction, as opposed to "a planned mechanistic process of cognitive transmission" (Cox, 2005, p. 4), its aim being to achieve genuine, motivated and relevant learning about what is needed in a specific practice. Learning is more than just acquiring knowledge, but results (and certainly in the case of the addiction recovery group intends to result) in a change of identity.

Table 4.1 Comparison of characteristics of traditional learning and situated learning (Lave & Wenger, in Cox, 2005)

Traditional cognitive approach to learning	Situated learning
Cognitive	(constructivism, situativism)
Teaching	Learning
Classroom	In situ
By teaching; by observation	By peripheral participation (i.e. social)
Pupil learns from teacher (individualised)	Learning from other learners (i.e. social)
Planned in a curriculum	Informal, driven by the task (though elements of the apprenticeship can be formal)
Learning is a mechanistic, cerebral process	Learning is about identity change via others

Lave and Wenger provided a viable alternative to the dominant cognitive paradigm for learning (Becket & Hagar, in Fuller et al., 2005) which could not account for how people learnt knowledge and skills outside of the context of formal educational or training.

4.2.3.2 Legitimate peripheral participation (LPP)

Lave and Wenger used the term "legitimate peripheral participation" (LPP) to describe the move to viewing learning as a situated activity, and hence enabled a shift to social participation. They also used the term to describe the process of how this division of both responsibility and labour is achieved in an apprenticeship context, where 'old-timers' and 'newcomers' relate through activities, identities, artefacts, and communities of knowledge and practice (Lave & Wenger, 1991). By connecting participation and meaning in a social context, and membership of a social practice to the participant's identity within that practice, Lave and Wenger took the concept of communities of practice beyond a mere forum for learning (Hodges, 1998). This was a breakthrough step.

Legitimate peripheral participation is a "theory of newcomer learning", where there is much emphasis on it being "a continuous, active, engaged, situated and identity-forming process — in contrast to the then dominant cognitive view" (Cox, 2005, p. 258). Learning is shared and experienced by the various participants within the specific learning context and is mediated by each participant's perspective (Kerno, 2008). This means, in fact, that the practice of recovery in one addiction recovery group could, and should, be different from the practice of recovery in another.

Lave and Wenger (1991) noted that "[f]or newcomers the purpose is not to learn from talk as a substitute for legitimate peripheral participation; it is to learn to talk as a key to legitimate peripheral participation" (pp. 108–109). The newcomers learn to speak the language of the practice; their membership and participation over time define them as insiders with specific knowledge and credibility.

Legitimate peripheral participation emphasises learning as specifically intentional, contextual and holistic, and offers a view of the person actively engaging in and with the world in a reciprocal process of transformation. This framework shifts the focus from learning as an individual cognitive process to one that is fundamentally social by focusing

on how increasing participation in ongoing practices with others generates changes in the person engaged in social activity. This orientation has the definite advantage of drawing attention to the need to understand knowledge and learning in context. However, situated learning depends on two claims: firstly, that it makes no sense to talk of knowledge that is decontextualised, abstract or general, as such knowledge is deemed meaningless; and secondly, that new knowledge and learning are properly conceived as far as being located in and emerging from a specific community of practice (Tennant, 2007). This is especially pertinent to this study, particularly in terms of answering the third critical question regarding the knowledge needed to maintain recovery.

Wenger added later that knowledge is developed at the core of a practice as well as at the peripheral interface with other communities of practice (brokering and reification) (Wenger, 1998b). He did not speak of "periphery" as being in the context of a newcomer to a practice, as he did in his earlier work, but rather spoke of "locality" (p. 122): the edge of a practice and its relationship to a participant who is a member of another practice, to both practices (brokering). This would be relevant in the case of one recovering addict describing or importing practices from another recovery support group. Examples of this include the 30- or 90-day chip that twelve-step members are given as a record of reaching that number of days of abstinence, or when a member of both a twelve-step programme and the recovery group of this study called other participants to put out chairs for the meeting, as that was the practice at the AA group he attended.

4.2.3.3 The apprenticeship model

Drawing on her background in anthropology, Lave introduced the notion of apprenticeship to social learning theory in the form of communities of practice theory (Fuller et al., 2005). In this context, apprenticeship does not relate to the craft guild tradition but to instances of communities of practice in contemporary society (Lave & Wenger, 1991). Apprenticeship is found wherever high levels of skill, knowledge and expertise are demanded — across a range of disciplines, including medicine, law, education, sports and the movie industry. As such, one can see that apprenticeship is the process by which new participants to an activity or practice gain the habits, skills and knowledge necessary for full participation in that practice. Apprenticeship has as its focus

the ‘other’; develops collaborative skills, such as problem solving; involves a variety of different roles, from newcomer to old-timer; and challenges ineffective strategies, habits and misconceptions, while encouraging constructive ones (Lave & Wenger, 1991).

According to communities of practice theory, upon entering the practice the apprentice’s initial participation is peripheral, but over time the learner begins to engage more fully as her membership status becomes more established. The learner “moves centripetally towards full participation, and in so doing both absorbs and is absorbed in the culture of practice” (Maynard, 2001, p. 41) as illustrated in Figure 4.1. Lave and Wenger used the words “community” and “practice” to explain that it was the practice within community that acted as a “living curriculum for the apprentice” (Wenger, 2006, p. 4).

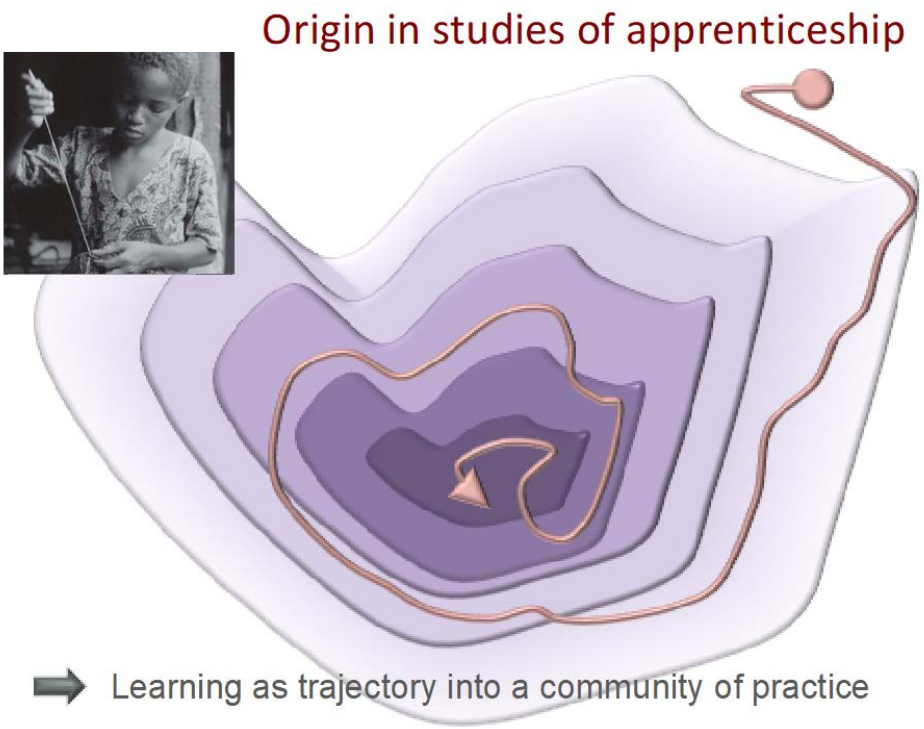


Figure 4.1 The trajectory of an apprentice from the periphery to full participation in a community of practice (Source: Presentation by Wenger-Trayner, 2017)[1]

[1] The photo in the slide image in Figure 4.1 is of a tailor in a Vai and Gola community of practice, one of the first examples of communities of practice identified by Lave (E. Wenger-Trayner, personal communication, July 17, 2017).

This model of participation does not rely on the idea that every newcomer enters into the same role with the same tasks and responsibilities but, instead, is based on the understanding that all of these components shift over time and space along with the learners' relationship to the whole. Learning as peripheral participation focuses on the trajectory of participation as one transitions from newcomer to full/er participation or old-timer (Lave & Wenger, 1991), and these trajectories are multidirectional, diverse (no two are the same), and situated in the social world. Lave and Wenger (1991) utilised the apprenticeship model in order to gain purchase on the inherently social, dynamic and situated nature of learning (Hodges, 1998). This concept also fits well with the notion of recovery in the group in this study insofar as each person learned, developed and maintained their recoveries according to their unique needs, abilities and challenges.

The apprenticeship framework highlights the wide range of social practices needed to study "the transformative possibilities of being and becoming complex, full cultural-historical participants in the world" (Lave & Wenger, 1991, p. 32). Apprenticeship moves beyond the focus of the situated activity or situated learning as merely a context or "container", and towards a more complex theory that views learning as relational, meaning as negotiated, and focuses on the various aspects of the person engaging with the world. This notion is relevant in the findings of this study. The world is socially constituted and the dialectical relations between the world and the person highlight the mutually constitutive nature of the world and people in activity (Lave & Wenger, 1991).

Lave and Wenger (1991) explained that the use of the terms "master" and "apprentice" enabled a way of thinking and talking about the ways that the social relations "in which persons and practices change, re-produce and transform each other" (p. 68). In terms of the apprenticeship model described, apprentices may gain more, relative to their knowledge status, upon joining a practice, but masters (seen as experienced practitioners with socially acknowledged greater levels of expertise) teach and continue to learn as a direct result of both their membership and their participation within the specific community. It was in further developing this concept that Lave and Wenger saw how widespread various practices were. Within this dynamic learning environment, everyone is involved in the learning experience and, similarly, everyone is involved in teaching through his or her own experience. In terms of the group in the study, the addiction

counsellors who co-facilitated often commented on how running the group regularly assisted with their focus and commitment to their own recoveries.

Even in those instances where a fixed doctrine is passed on from master to apprentice, the ability of a practice to reproduce itself is not based in the doctrine or the knowledge, but rather in the continued maintenance and replications of certain modes of participation in which the knowledge and curriculum is embedded (Kerno, 2008). These particular ways of relating are the key to social learning and, in this case, the practice of addiction recovery. In the communities of practice theory, learning is not distinct from the becoming of the learner. Hence the centrality of the notion of identity.

Usually included in a curriculum is a conception of knowledge, but knowledge is not a technical term in this theory. In communities of practice, similar but not exact technical terms include practice, regime of competence and knowledgeability, and claims to competence within a particular practice. The reason for this relates to notions of power, and whose practice and competence becomes conceptualised as 'knowledge' is a complex historical, social and political process (Farnsworth et al., 2016).

Thus, part of the contribution of this study is to examine and reveal these modes of participation — including the practice, Membership and Regime of Competence in this particular addiction recovery group — in this way illuminating how addicts learn to recover via an addiction support group. This can be found in Chapter 13, which integrates findings from interviews and focus groups with these and other aspects of this theory.

4.2.3.4 Phases of development of the communities of practice theory

To summarise, the communities of practice theory involves three main phases:

- **Phase 1: Access to competence**
  In the first phase, the community was almost taken for granted and learning was viewed as the trajectory into it. Some of the key technical terms here include situated learning, old-timer, newcomer, legitimate peripheral participation and access to practice (Lave, 1993, 1996; Lave & Wenger, 1991, 1999; Wenger & Lave, 2001). The main contribution to phase one is Lave and Wenger's (1991)

Situated learning: Legitimate peripheral participation, which has been cited over 65 000 times.

- **Phase 2: Negotiating competence**

  In this second phase of the theory's development, the notion that learning is a form of social engagement was fundamental, and that the community was formed over time when people negotiated the competence of the practice.

  Some of the key technical terms in this phase include identity, regime of competence, participation-reification, negotiation of meaning, genre as performance and continued professional development (Wenger, 1998b, 2000, 2008a; Wenger, 2010; Wenger, 2011; Wenger et al., 2002; Wenger et al., 2009; Wenger-Trayner, 2013). The main book in phase two is Wenger's (1998) *Communities of practice: Learning, identity and meaning*, which has been cited over 50 000 times.

  These two phases offer useful concepts to assist with the answering of the critical questions in this study as they focus on a single community of practice.

- **Phase 3: Competence and knowledgeability**

  In the third phase of the theory's development, learning is not considered only to be a simple trajectory into one community of practice, but is also a trajectory across a landscape of different communities, networks and other social organisations. While in the first two phases competence is defined within the community of practice, in the third phase the theory speaks of knowledgeability being defined in relation to a landscape of practice. In the third phase, identity is negotiated across a complex landscape of practices, whereas in the first two phases, it is negotiated within one community of practice. In the third phase, the negotiation is more intense, according to Etienne Wenger-Trayner, as one has to modulate one's participation across multiple potential locations across the landscape. This influences and forms part of the development of one's identity.

  Some key technical terms in this third phase of the theory include boundaries, learning ethic, social learning spaces, landscapes of practice, vertical, horizontal, transversal accountability, imagination, engagement and alignment,

brokering/boundary objects, knowledgeability) (Farnsworth et al., 2016; Wenger-Trayner & Wenger-Trayner, 2014).

The present study uses technical terms from phases one and two, as those phases focus on identity development and transformation within a community of practice, rather than phase three, which focuses on identity development and transformation across practices and various types of social groupings, and as such are not relevant to the work of this study. The main technical terms and concepts that are used in this study include situated learning, Membership, old-timer, newcomer, legitimate peripheral participation, identity, and Regime of Competence.

4.2.3.5 Joint enterprise, mutual engagement and shared repertoire

Wenger (1998b) notes that a community of practice relies on three interrelated concepts: mutual engagement, joint enterprise, and shared repertoire. Firstly, members interact with one another and, in doing so, establish social norms and build relationships; this is termed mutual engagement. Secondly, through their interactions, they create an understanding of the shared interests that bind them together; this is termed the joint enterprise. Finally, over time, they produce a set of communal resources, termed their shared repertoire, which they use in the pursuit of their joint enterprise. This shared repertoire can include both symbolic and literal meanings, such as symbols, rituals and language, as well as physical artefacts, such as documents, methods and standards. An example of a standard in the recovery group would be how one would measure sobriety. In the group in this study, as well as in AA, it is measured through the beginning ritual when participants introduce themselves, stating their name, drug of choice and length of time of total abstinence from any intoxicating substance.

Wenger (1998b) posits that it is through joint enterprise, mutual engagement, and shared repertoire that a community establishes guidelines as to "what it is to be a competent participant, an outsider, or somewhere in between" (p. 137), and adds that establishing such guidelines is crucial for learning to take place in a specific community of practice.

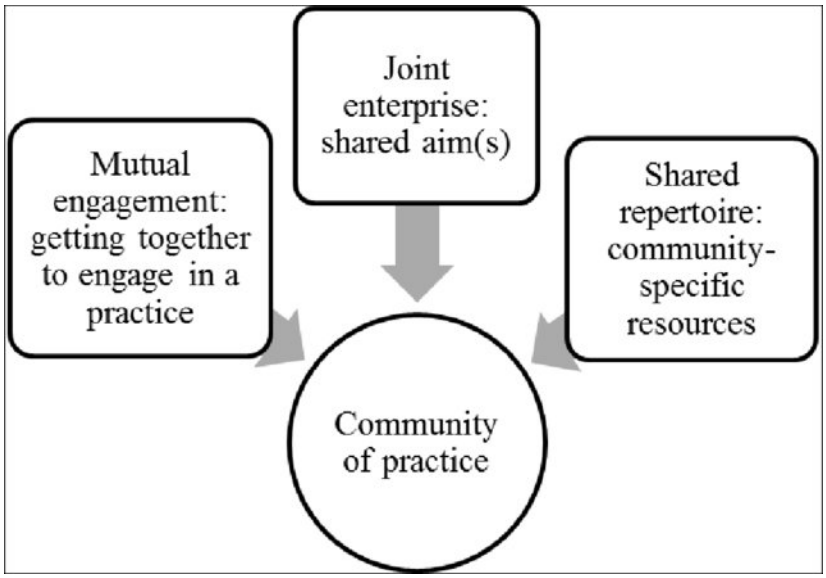


Figure 4.2 Key concepts on which a community of practice relies (Limatius, 2016)

Wenger argued that the elements of a community of practice which distinguish it from other groups, networks and communities include a domain of knowledge, a notion of community and a practice (Wenger, 2011). “Domain” refers to a shared competence, topic, or subject of interest that distinguishes members from other people. A “community” refers to the engagement in joint activities and conversations members of a practice have while pursuing their interest in their domain. Here they build relationships that facilitate mutual learning. The notion of practice refers to the development of a shared repertoire of skills, tools, stories, modes of relating and various resources in order to pursue the reason for being together. This occurs over time (Wenger, 2011).

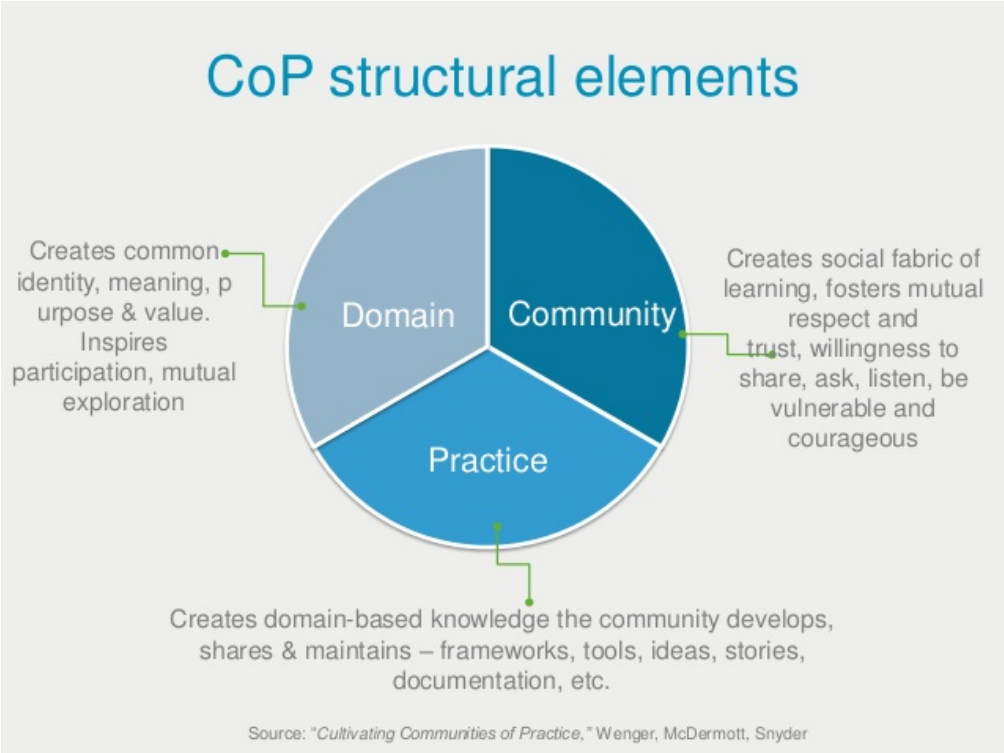


Figure 4.3 Structural elements of a community of practice (Wenger et al., 2002)

4.2.3.6 Reification and participation

For Wenger, communities of practice are learning communities in which there exists an exchange between reification and participation. Reification refers to the artefacts and procedures of previous practice (previous attempts on behalf of the addict to stay clean and what the addicts learnt from each one, for example). Reification, as it relates to the negotiation of meaning, is "the process of giving form to experience by producing objects that render this experience into 'thingness.' In so doing we create points of focus around which the negotiation of meaning becomes organized" (Wenger, 1998b, p. 58). An example of this is the cake given to each group participant upon achieving another year of recovery.

Participation is the activity of the participant in a practice that results in reification — the transformation of the identity of the addict from using to being in recovery, by bringing who they were and what they did, participating in the new practice, and emerging through this ongoing negotiation, with a transformed sense of self and meaning. This global transformation takes time, commitment and consistency to perform and needs to be done in a supportive and understanding context.

4.2.3.7 Duality

In Wenger's (1998) understanding of a social theory of learning, "the four necessary components of the domain of learning — community (learning through belonging), identity (learning as becoming), meaning (learning as experience) and practice (learning as doing) — are integrated in a way that characterises social participation as a process of learning and knowing" (Wenger, 1998b, pp. 4–5).

Figure 4.4 Components of the domain of learning (Wenger, 1998b, p. 212)

The key notions of learning being a focus on identity and on meaning are important in this study. Wenger no longer refers to legitimate peripheral participation, which is relevant to this present study, and instead moves on to describe a community of practice in a different way, jettisoning the apprenticeship aspect for four dualities: participation-reification, designed-emergent, identification-negotiability and local-global.

Wenger here introduces the notion of duality to convey the dynamism of the tension between two (arguably opposing) forces, which become a driving force for change and creativity. This interchange is where the rebirth of identity emerges. Wenger (1998b) uses the notion of dualities to explain and analyse the forces that create and sustain a community of practice (Wenger, 1998a). This introduces the notion of dynamics into the theory, where the individual negotiates within the two elements.

Some compare the concept of a duality to that of yin and yang, i.e. two mutually defining opposites where both, together, form the whole and their synergy is the dynamic energy for growth and creativity. In a sense, the ultimate dualism is life and death, and this was addressed by Freud in the drive aspect of his theory (Marlatt et al., 2012). In this study this can be seen in the playing out of the relapse-abstinence trajectory typical of addiction recovery. Also, in this study, the practice can be seen as the crucible containing these two oppositional forces while the individual engages with them in herself via others.

The participation-reification duality is primarily involved with the understanding of meaning created through active involvement in a practice. Reification is a way of making an abstract concept into a concise representation of what is often a complex and frequently messy aspect of practice, making it easier to share, teach and learn (Euerby & Burns, 2012). Wenger explains that the negotiation of meaning is continually undertaken. In all situations, individuals "produce meanings that extend, redirect, dismiss, reinterpret, modify or con-firm … the histories of meanings of which they are part" (Wenger, 1998b, p. 52).

The specific duality also links to knowledge (of the domain) — an example being 'shorthand' ways that participants in a practice explain certain relevant skills or understandings needed (Hildreth & Kimble, 2002). A good example is Wenger's term of "purple in the nose" in the wine-tasting community of practice meaning something very different outside it. Similarly, "use your steps" in a twelve-step addiction recovery community, refers to just that, and not actual stairs as it would outside that community of practice; or "days" referring to days of sobriety specifically within the addiction recovery community. This signifies how the purpose is not to learn from talk as a substitute for practice but to learn to talk as key to being a member of that practice.

4.2.3.8 Identity: learning as knowing, being, and valuing

Lave and Wenger (1991) made their epistemic and ontological assumptions clear in their overarching premise that learning entails the transformation of people and of communities. Because learning transforms who we are and what we can do, it is an experience of identity. It is not just an accumulation of skills and information, but a process of becoming — to become a certain person or, conversely, to avoid becoming a

certain person (Wenger, 1998b). Knowing, identity and values are linked through the understanding that learning takes place through ongoing participation and interaction with others in a valued social community that involves changes in the whole human being. Lave and Wenger (1991) explained that learning is recognised as a social phenomenon, constituted in the experienced, lived-in world through legitimate peripheral participation in ongoing social practice; the process of changing knowledgeable skill is subsumed in processes of changing identity in and through membership in a community of practitioners; and mastery is an organisational, relational characteristic of communities of practice. De Beer (2003), a South African social worker, parodied Descartes' famous words by changing "I think, therefore I am," to "I participate, therefore I am", making reference to ubuntu with this quote (De Beer, 2003).

This model focuses on the ongoing transformations of people, of practices and of the field of social relations through which they take place in order to conceptualise learning as neither wholly subjective nor entirely intersubjective, but as a blend of the subjective and intersubjective, as mediated by the specific context in which it is situated (Lave & Wenger, 1991).

Lave and Wenger (1991) conceived of identities as "long-term, living relations between persons and their place and participation in communities of practice" (p. 53). Wenger (1998b) argued that learning transforms who we are and creates "personal histories of becoming" in relation to our communities, thus linking knowing and being (p. 5). Lave and Wenger (1991) described identity as dependent upon our interaction and activities with others. The authors explained that identity construction "is also a way of speaking of the community's constitution of itself through the activity of its practitioners" (Lave & Wenger, 1991, p. 74) and that without participation there may be "no basis for lived identity" (Lave & Wenger, 1991, p. 74). In this way, participation is essential for the construction of values.

Lave and Wenger (1991) proposed that, as an integral component of social practice, learning involves the whole person in relation to the community, thus implying that the learner becomes a "participant, a member, a specific kind of person" (p. 53). They argued that "learning thus implies becoming a different person with respect to the possibilities enabled by these systems of relations" (p. 53). This study is an illustration of the transformation of the whole person through participation in a community of practice,

where the addict's identity — which consists of her values, emotions, physicality and spirituality — are transformed through her participation over time in the practice. In communities of practice theory, learning is viewed as co-construction and emphasises the importance of old-timers in structuring and shaping the social practices and relationships that contribute to the newcomers' learning. Participation and membership do not rely on agreement, cohesion, or acceptance; importantly, dissent, resistance and challenge may even be valued aspects of social relationships and practices within a community. And even if they are not considered as such, within a specific community the concept of community is not defined by homogeneity or consensus. This is exemplified by the participants in this study saying repeatedly, referencing recovery, that "one size does not fit all": each person must do what works for him or her regarding the integrity of their unique recovery.

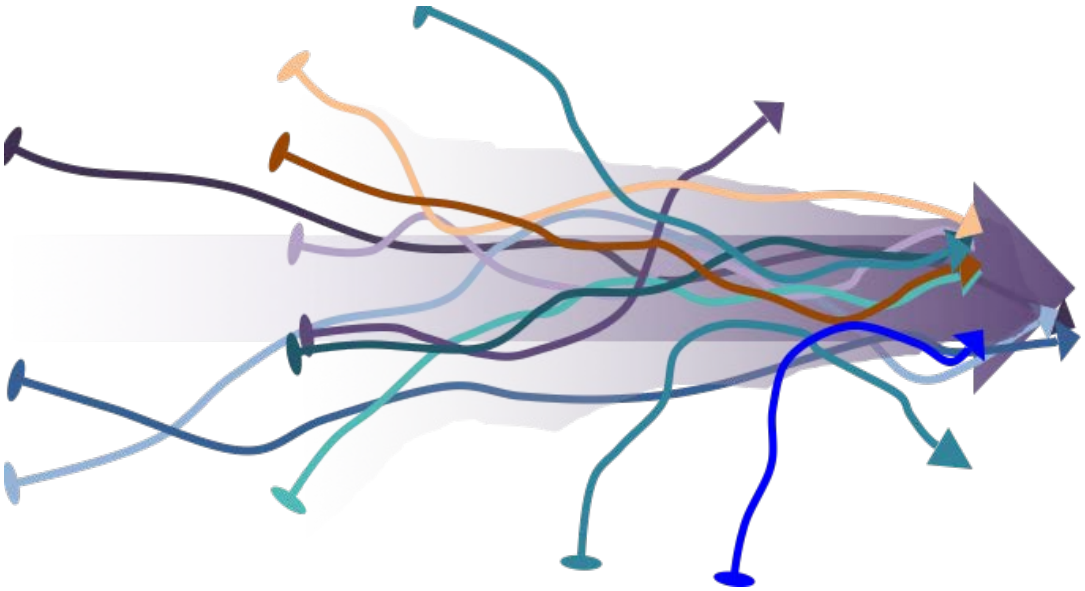


Figure 4.5 Each participant journeys through time and through a community of practice, developing her identity (Source: Presentation by Wenger-Trayner and Wenger-Trayner at Academic Retreat, 17 July 2017)

Through time, the acquired knowledge is internalised through both belonging and participating in the community). Then one is seen by others in that practice in the light of this new identity, because one is living and embodying the new knowledge. One feels a legitimation of one's place and competence in the practice. Consequently, learning becomes part of a "generative social practice in the lived in world" (Lave & Wenger, 1991, p. 35). These are all salient aspects of this study.

For Wenger, time and space are critical theoretical aspects, as learning and identity transformation happen in a specific practice (space) over time (Farnsworth et al., 2016). These aspects link closely with the maintenance of sobriety in twelve-step groups, which is directly associated with participation in a practice over a length of time.

4.2.4 Alcoholics Anonymous as a community of practice

Lave and Wenger's seminal work (1991) refers to AA as an example of a community of practice. It is fascinating that group recovery from addiction was acknowledged as an example of community of practice from the first emergence of the concept. Interestingly, according to both my own research and a personal communication from Etienne Wenger-Trayner (July 2017) during a BEtreat, there has been no further investigation of this particular community of practice (addiction recovery) until the present research. This research then will make a contribution to the practice of addiction recovery and to the theory of communities of practice.

AA as an example of a community of practice is particularly helpful in elucidating the concepts of apprenticeship, social practices and learning as knowing, being and valuing. AA is a particular 'cultural system' that consists of beliefs, identities, values, and behaviours alongside specific ways of dealing with and interpreting experiences and events (Lave & Wenger, 1991). AA's social practices are grounded in storytelling with the goal of constructing a life story, or narrative, which contributes to a new identity and "new meaning of the teller's past and future action in the world" (Lave & Wenger, 1991, p. 73). Newcomers gain access to the community's overarching goals and objectives through meetings and organisational literature, by observing old-timers as they model storytelling, and by spending time interacting with new peers, practitioners and old-timers. Over time, their participation changes as they construct a new identity of themselves as non-drinking alcoholics and as they eventually become recognised as full participants and, eventually, old-timers (Lave & Wenger, 1991).

Hodges (1998) maintains that Lave and Wenger failed to seize the opportunity to explore how AA, as an organisation that grew from a localised movement into a global network, interacts with and mutually influences the more localised participation in communities of practice. However, this critique is responded to in their 2014 work, *Landscapes of*

practice (Wenger-Trayner & Wenger-Trayner, 2014), which focuses on individual identity and trajectory through landscapes of practice. The broader terrain described in the third phase of the theory responds to the earlier critique and could assist an account of the global spread of many different AA groupings across the world.

While Cain's (1991) pioneering work on AA, which was cited as one of the first practices in Lave and Wenger (1991), had a narrative focus and explored individual accounts of AA, the present study has a hermeneutic focus and examines the mechanisms within the group (practice of addiction recovery) to understand how they contribute to the participant's transformation and sustained recovery. There is a particular focus on identity transformation through participation in the practice, meaning changes through recovery and accountability through the regime of competence. No such work has been done before, and this work hopes to reveal the group addiction recovery mechanisms inherent in a particular community of practice as it existed in a particular time and place.

4.2.5 Applications of the theory of communities of practice

The communities of practice theory has been applied in educational research to investigate such varied topics as the professional development of teachers (Sutherland, Scanlon, & Sperring, 2005); issues in engaging students in communities of practice through a school-university partnership (Sutherland et al., 2005); the creation of online learning communities (Barab, MaKinster, Moore, & Cunningham, 2001); inclusive education (Miles, 2007); mathematics education (Solomon, 2007); vocational education (Farnsworth & Higham, 2012); and gender studies (Paechter, 2003).

Communities of practice has been popularly applied in South Africa in educational research, including investigating the identity formation of new academics in a community of practice (Jawitz, 2009); the use of Facebook as a teaching tool at the University of Cape Town (Bosch, 2009); and the practice and policy regarding ICT for education (Vandeyar, 2013). Research has also been done on rural pre-service teacher education (Islam, 2012); confidence in mathematics teacher learning (Graven, 2004); a community-based organisation case study (John, 2009); and adult learning in a Bible study home group (Spooner, 2012).

Communities of practice theory has been applied to a number of aspects of addiction, including the development of masculine identity and smoking behaviour in children (Paechter, 2003); alcohol consumption and gender roles (Lyons & Willott, 2008); British public houses and habitus (Mutch, 2003); hearing the student voice (Mitra, 2008); online addiction (Wolf, 2007); patient pathways from alcoholism (Whiteford & Byrne, 2015); and substance abuse education in the Caribbean (Reid et al., 2016).

I searched fruitlessly for studies that had used communities of practice theory to investigate the role of addiction recovery. I had assumed that AA or other twelve-step groups would prove ideal communities for such research. I discussed this with Etienne and Bev Wenger-Trayner in person;[2] they indicated that they, too, knew of no previous research in this area. This suggests that this study will contribute to the research on communities of practice theory in the context of addiction recovery practice.

4.2.6 Critiques of communities of practice

As the theory of communities of practice has evolved, various aspects have come under criticism; some of these criticisms have been addressed by Wenger as he and others have continued to develop the theory.

Kell (2004) posited that the theory of communities of practice was inadequate insofar as the original idea was anthropological in nature and was being forced and contrived to become a technological application and explanation for learning, thus sacrificing the spontaneous nature that is native to communities of practice. In 2005, the theory was criticised for neglecting the cognitive aspects of learning, thereby overlooking the theory's origins in socio-cultural and activity theory, which emphasised this far more strongly (Edwards, 2005). Trowler (2005, in John, 2009) argued that Wenger emphasised harmonious relationships and shared knowledgeability — seeing groups as closed systems — and neglected the power dynamics in communities while focusing only on a one-way trajectory from the periphery to the core of the practice. Others (Edwards, 2005; Fuller et al., 2005) argued that the explanation that learning is legitimated through

[2] I participated in the Wenger-Trayners' four-day online and face-to-face BEtreats in 2015 and 2017 (http://wenger-trayner.com/betreat/)

"acceptance by and interaction with acknowledged adept practitioners" (Lave & Wenger, 1991, p. 100) is vague and ignores alternative modes of participation and learning, such as rejection or resistance. This is important in the context of an addiction recovery group, where resistance in the form of relapse would be common.

Kimble (2006) posits that Lave and Wenger had conceived of the community as an independent, discrete entity, failing to account for the broader social network — with its stresses, tensions and alternative communities — within which a community finds itself. Wenger (1998a) and Wenger-Trayner and Wenger-Trayner (2014) later addressed this critique.

In terms of an example of a problematic practice, Hodges (1998) writes using a feminist lens of her struggles with learning as participation and identification, as well as her own (non)participation and eventual dis-identification with teaching. Her ambivalence and tension around the identification aspects of identity illustrate how important it is to have a practice that does not limit the expressability of identity. The critique is not on the theory but on the rigid teacher identity that she was unable to adhere to, as it was disingenuous to other aspects of her identity. As Etienne Wenger-Trayner says in an interview relating to participants in a community of practice: "when you impoverish their experience of who they are to the point where the rest of their lives is not supposed to exist, how can you expect that to transfer?" (Farnsworth et al., 2016, p. 16). Hodges' example is a good one of how social learning fails because of the rigidity of the practice. This is not a theoretical but a practical critique because this study is drawn from praxis and will hopefully be applied to recovery praxis in the future.

4.2.7 Diagrammatic summary of key technical terms from Lave and Wenger's (1991) and Wenger's (1998) communities of practice theory as relevant to the present study

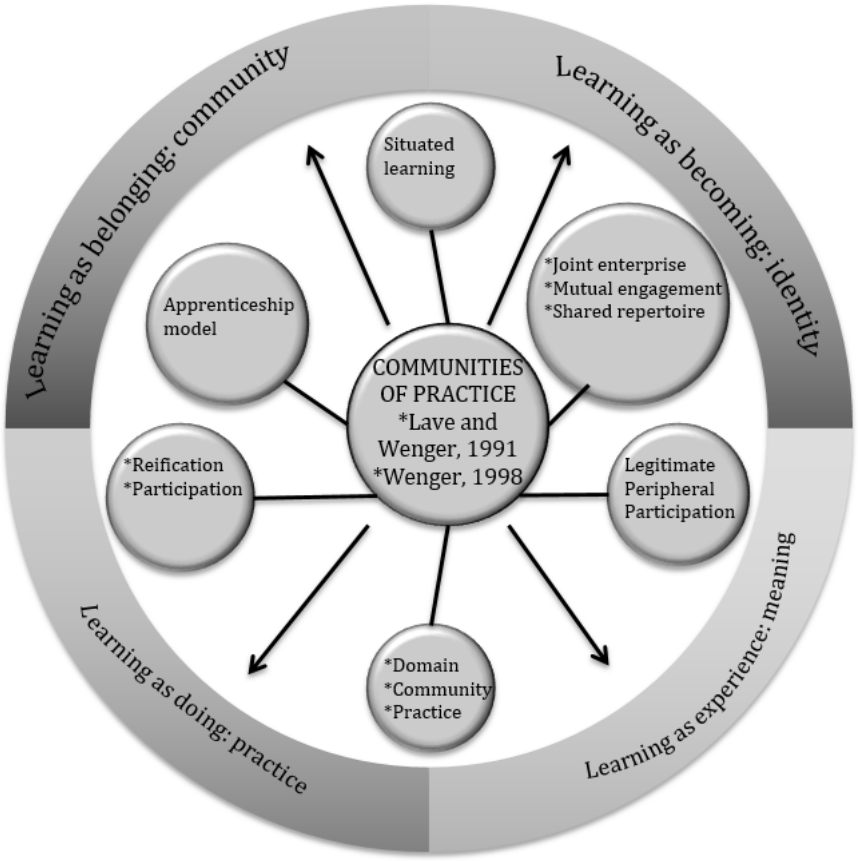


Figure 4.6 Summary of the technical terms of communities of practice theory

4.3 PSYCHOANALYTIC THEORIES OF THE AETIOLOGY OF ADDICTION

This section expands on psychological constructions and understandings of identity construction to deepen such understanding through a group process. It unpacks the psychoanalytic understandings informing addiction and recovery as well as the development of addiction within the self. The psychoanalytic model helped me, as the psychologist facilitating the recovery group, to conceptualise participants' issues in terms of mental illness and health in relation to their addiction recoveries and development. However, as the group was also co-facilitated by a layperson (the addiction counsellor)

and was not set up as a psychoanalytic group, I did not work psychoanalytically in the group. Psychoanalytic theory holds that addiction originates in early relationship, and an assumption of this study is that recovery is maintained through relating via social learning and group participation.

4.3.1 Introduction

A number of psychoanalytic models have developed to explain the phenomenon of addiction. As with the communities of practice theory, these highlight different aspects of how relationship contributes to the identity development of the individual. Interestingly, even Freud, the originator of individual psychoanalysis, noted that

> the contrast between individual psychology and social or group psychology, which at first glance may be full of significance, loses a great deal of its sharpness when it is examined more closely … but only rarely and in exceptional conditions is individual psychology in a position to disregard the relations of this individual to others … and so from the first individual psychology, in this extended but entirely justifiable sense of the words, is at the same time social psychology as well. (Freud, 1921, p. 1)

For Freud, the consideration of both the individual and social aspects of identity construction were fundamental.

Two psychodynamic experts and pioneers in the addiction field, Ed Khantzian and Martin Weegmann (Weegmann & Khantzian, 2017), have asked the following questions, which resonate with this study and can be applied to recovery within a group format. They have pondered how psychological growth and integration are promoted in recovering individuals, and what needs to occur for recovering addicts to move from attachment to their substances of choice to becoming constructive human beings. They have asked about how resilience within a self-structure of the individual's psyche is constructed through recovery. However, both concur that at "this stage in the 'science' of recovery, it is perhaps too early to be sure of the answers" (Weegmann & Khantzian, 2017, p. 80).

The present study contributes to this conversation by bringing some thought to the answering of these questions regarding the science of recovery.

4.3.2 The evolution of psychoanalytic perspectives on addiction

Various researchers have contributed to the psychoanalytic epistemology. In the late 1880s, Freud was the first to write on the topic, writing about the uses of cocaine — something he knew well from personal experience. In his paper "Über Coca" (Freud, 1884), Freud endorsed using the drug for recreation, enthusing:

> You perceive an increase of self-control and possess more vitality and capacity for work. ... In other words, you are simply normal, and it is soon hard to believe you are under the influence of any drug. ... Long intensive physical work is performed without any fatigue. ... This result is enjoyed without any of the unpleasant after-effects that follow exhilaration brought about by alcohol. ... Absolutely no craving for the further use of cocaine appears after the first, or even after repeated taking of the drug. (p. 205)

This aptly describes part of why many addicts maintain their addiction — because it is so extremely enjoyable. This speaks to the neurological reward that the brain is delivered through addiction.

However, Freud seriously reconsidered his stance in 1900: "I had been the first to recommend the use of cocaine in 1884, and this recommendation has brought serious reproaches down on me. The misuse of that drug has hastened the death of a dear friend of mine" (Byck & Freud, 1975, p. 211).

Freud's addiction theory was based on the id dynamic explained by Morgenstern and Leeds (1993) as depression originating from an instinctual disorder interfering with the general well-being of the addict, which motivates the removal of the disturbance (depression) by means of the temporary, but powerful, drug euphoria. Right from early psychoanalytic writing, the link was made between a substance of choice being used to ameliorate a difficult and unpleasant emotion in the user.

Rado (1933) argued that the study of addiction must begin with the recognition that it is not the toxic agent, but the impulse to use it, that makes an addict out of a given individual" (Rado, 1933, p. 2). Here the usefulness of the psychoanalytic approach can be seen — turning away from the substance and focusing on the relational issues and personality of the user. This is in contrast to the 'war on drugs', with its drug focus, in

which trillions of dollars have been spent to eliminate drugs, while 90 Americans die each day from opioid overdose (Librett, 2018). Only recently has the recovery movement begun to focus on the user and look at why people use drugs and what support they need in order to stop (Laudet, 2007, 2013).

Glover (1956) suggested that substance use could be seen as adaptive for the individual. Krystal (1978) saw the problem as lying in the distortion of relations between objects — which makes sense given the mechanism of splitting in narcissistic organisation. He introduced the notion of viewing the substance through the lens of object relationships, looking at the user's relationship with that substance and the function it serves as a replacement for the relationships with both the self and with others (Krystal, 1978). In addiction, self-soothing is split off and attributed to a substance, instead of the individual being able to internalise and activate their own ability to self-soothe (Krystal, 1978).

Wurmser (1974) proposed that substance abuse is motivated by a narcissistic crisis; he advocated psychoanalysis as central to treatment, listing affect tolerance, reduced ability to symbolise emotions and experiences and pathology within the superego as factors which drive substance use. McDougal (1984, 1989, 2001) conceived of substance use disorder as a psychosomatic illness emerging as a defensive mode of dealing with distress — supporting the idea of artful contrivance within the narcissistic organisation. In these theories, the links between addiction, relationship and emotional regulation are consistent.

Some psychoanalysts have viewed addiction as a purely psychological condition. Dodes (1990, 1996, 2002, 2004) advocated this and wrote, for example, about the short-lived physical aspects of addiction after detoxing compared to the long-term psychological aspects which need to be addressed (Dodes, 2004). Rinsley (1988) noted that the inability of addicts to self-soothe is similar to the problems he encountered in the psychological structure of people with a borderline personality disorder. For Walant (1995), a denial and devaluation of merger moments (with the good object) throughout the life cycle increased the likelihood of addiction. She held that premature autonomy and independence are encouraged at the expense of attachment needs, and as such, the person is incapable of self-soothing or whole-object relating. For Kohut (2013) and Van Schoor (1992), narcissistic, or self, disturbances were central to the psychopathology of the addict: internally, the addict feels empty, fragmented and chaotic; alcoholism is a

pathological compromise to compensate for the depleted sense of self and its concomitant unmanageable feelings (Kohut, 2013; Van Schoor, 1992). These theorists alluded to problematic early attachments as being the root cause of addiction.

Other research has also viewed addiction as having a psychological aetiology. This includes research by Director (2002, 2005) and Petrucelli and Stuart (2001), who have researched omnipotence and the control the addict needs to exert over her world through her addiction due to the belief that her needs cannot be met by herself and others. Other psychoanalytic writers on addiction include Burton (2005), Mann (2002), and Waska (2006).

The advantage of the psychoanalytic approach is that it features hundreds of systematic observations of a single patient, made over time. Psychoanalysts treat addiction by examining their relationship with the patient and use psychodynamic principles. An interpersonal vantage point produces different data about the disease of addiction and, from there, inductive conclusions can be reached and theory written (Johnson, 2011).

Over time, psychoanalytic literature on addiction has become more focused on relationships and the relationship between substance use and interpersonal relationships has become emphasised. Director (2005) has shown this through her tracking of the transference-countertransference patterns in treatment. Relational positions have also been described in the work of both Burton (2005) and Rothschild (2007, 2010), who have written about specific self-states and aspects of personality.

4.3.2.1 Addiction as self-medication

The idea that the addict could be using substances for an adaptive (emotionally regulative) reason laid the foundation for the self-medication hypothesis (SMH) developed by Dr Ed Khantzian in 1975 (Khantzian, 1975). During the 1970s and 1980s, Khantzian did much to humanise addiction by proposing that the choice of substance is not random, but specific to meeting the individual's psychological needs. Substance use is an attempt to compensate for a flawed self-concept, and substances are used as substitutes for aspects of the self to regulate difficult emotion (Khantzian et al., 1990).

Khantzian's 1999 classic work *Treating addiction as a human process* challenged the stigma associated with addiction. He and others debunked the prevailing notions that addiction resulted from hedonism, sociopathy or self-destructiveness. Substances of abuse assist such individuals to relieve painful affects, or to experience or control their emotions when they are absent or confusing (Khantzian, 1997). This exposed the vulnerability of the addict, marking an important shift away from a strictly psychopathological perspective, showing a more human and less stigmatised side to the addict (Khantzian et al., 1990).

Arguably the greatest contribution of this theory is that it offers an explanation as to why only a minority of individuals who use drugs become dependent: the need to master and regulate psychological problems and thus the self. One such problem found in addicts is alexithymia — the inability to put feelings into words — which results in a compromised ability to process feelings and thus be able to regulate behaviour (Khantzian, 1990). Khantzian et al. (1990) noted that many opiate addicts have issues managing rage and anger, often stemming from experiences of traumatic violence. The concept of using a psychoactive substance to cope with an emotion forms the basis of his self-medication hypothesis (Khantzian, 1975, 1987, 1990, 1997, 1999, 2012).

This theory is not intended to replace sociocultural and biogenetic theories in explaining the aetiology of substance-related disorders. Instead, it works well with these other perspectives, addressing important emotional and psychological dimensions of addiction that had previously been dismissed (Khantzian, 1997).

Khantzian's theory failed, initially, to account for two phenomena, although these were later addressed. The first is that some people struggle with difficult emotions but do not self-medicate with substances as a way to cope; secondly, the use of addictive substances ultimately causes the person more pain than they relieve. Khantzian (1990, 1995, 1997) refined his theory to consider addiction as a self-regulation disorder. He became a strong advocate for a group intervention as a corrective emotional experience for addicts — in part, because as much as addicts suffer with self-regulation vulnerabilities, they also defend against them by using their addictive substances (Khantzian, 2016).

The mechanisms of the recovery group that work with the connection between addiction and self — leading to identity transformation in its participants — are the focus and theoretical contribution of this study.

4.3.3 Addiction as an attachment disorder

Attachment theory, developed by John Bowlby (Bowlby, 1980; Raw et al., 2010; Sitas et al., 2013), provides one of the most recognised models for the understanding of early relationships between the child and the caregiver (Potter-Efron & Potter-Efron, 1999). Another offshoot of psychoanalysis, attachment theory views addiction as having a relational cause and works well with Khantzian's self-medication hypothesis.

In this theory, substance abuse is considered as "a faulty activation of attachment strategies stemming from insecure attachment relationships in infancy and early childhood" (Drake et al., 2006, p. 531). The disturbed connection between caregiver and child interferes with the normal development of the neural networks that enable the child to regulate his emotional states. (This can be caused by trauma as well.) As a result, the person chronically experiences unmanageable emotional distress.

Early trauma, rejection or neglect is often found in the histories of addicted people lacking physical and emotional closeness during childhood (Höfler & Kooyman, 1996). Sachs (2009) noted that many individuals struggling with alcoholism have also struggled to separate from parental figures, resulting in adults with attachment styles that range from either detached, isolated or overly self-sufficient to those who are emotionally needy and want to enmesh. These problematic attachment styles are related to having negative self-perceptions, which affect the development of intimate, healthy and mutually satisfying relationships and instead create a vulnerability to using addictive behaviours and substances to meet attachment needs (Sachs, 2009). Bowlby (1979) and Ainsworth (1989) regarded an insecure attachment as being a repertoire of protective strategies designed to maintain connection with caregivers who are hurtful, damaging, unavailable or inconsistent. Relational issues (e.g. coping with interpersonal conflict, and developing intimate relationships) are present in the majority of individuals with addiction issues (White, 1998). Individuals who do not experience secure attachment in their early years are vulnerable to developing addictive behaviours in adolescence, as the drug of choice

"seems to offer a solution to those adolescents who feel unlovable, who might have felt like this for a long time, who have sometimes suffered a history of early trauma and neglect and, consequently developed a negative self-concept" (Höfler & Kooyman, 1996, p. 516).

The links between self-regulation and attachment support the definition of addiction as an attachment disorder both in terms of its aetiology and its consequences (Flores, 2001, 2004). The addicts' 'drug of choice' becomes at the same time a substitute for and an obstacle to developing interpersonal relationships (Flores, 2006). Phillip Flores, a leading addiction specialist and psychological theorist in this area, stated: "Addiction is a disorder in self-regulation. Individuals who become dependent on addictive substances cannot regulate their emotions, self-care, self-esteem, and relationships" (Flores, 2006, xi). Flores (2006) linked the human need for social interaction to the well-being of the nervous system and avers that, in addiction, the mechanisms for healthy attachment become 'hijacked' and the person becomes dependent on his addiction. Unless a person has experienced consistent emotional management through loving, consistent caregiving from infancy, aspects of their neurological systems do not develop properly and this is the foundation of later addiction. Recent neurobiology research provides evidence that neurophysiological development and functioning are influenced by the availability and experience of secure attachments (Flores, 2001). Thus, interpersonal relationships define our capacity for neurophysiological regulation. Attachment theory provides a perspective to understand this process (Flores, 2001; Lyvers et al., 2010). Addicts have been found to use their substance of choice as a compensatory mechanism for self-regulation; however, as the addiction progresses this results in worsening the dysregulation within the attachment system (Padykula & Conklin, 2010).

Flores (2006, p. 6) noted that addicts often struggled with forming intimate emotional bonds with others even before their addiction began. Learning how to form healthy emotional attachments and then develop them is necessary for an addict to achieve long-term recovery. The unconditional acceptance that the addict feels when she enters a twelve-step meeting provides an opportunity for healthy attachment and meets the addict's deep needs for feeling safe, wanted and contained (Flores, 2004). Flores (2004) holds that this sustained, unconditional acceptance, which is the foundation of relationship building, is a fundamental aspect of the success of twelve-step groups. An

accepting and welcoming recovery group is thus the ideal treatment mode for an addict with underlying attachment and emotional regulation issues to learn to recover.

4.3.4 Addiction as a search for secure attachment

Director (2005), an attachment specialist, suggested that addicts live in a confused, helpless state, unsure of how to meet their needs because they did not experience positive mothering. Once they discover the power of a substance to temporarily alleviate this discomfort, addicts seek out substances aggressively as a means to meet their needs; over time this becomes the central organising principle of their lives (Director, 2005). They 'fall in love' with this constant provider and soother, which brings them security, relief, safety and meaning. There is a similarity in this experience to the "moment of illusion" first described by Winnicott (1945, p. 152). This has been explained by Director (2005) as the belief that other people can provide support during difficult times — first experienced by a baby when struggling with breastfeeding, then repeated across one's lifespan (Director, 2005). This notion is critical to this study. In the case of addiction, the relationship is actually with an object which, rather than providing mutuality or satiation, ultimately perpetuates the frustrations and disappointments within the addict, who pushes others away as ruthlessly as his needs were pushed aside as an infant (Director, 2005, pp. 567–587).

All that matters to the addict is obtaining her substance of choice, which will bring her union (in her fantasy) with all she desires. Should this union be threatened in any way, the addict will defend it and fight for it ruthlessly. One can see here the daunting challenges facing those who work with addicts, as well as the rejection and suffering experienced by those close to the addict (Director, 2005).

Director (2005) held that the addict thus achieves a false sense of omnipotence through her control of her substance of choice. For treatment to be effective, it must have the capacity to hold and contain these defensive omnipotent feelings. In early treatment this is demonstrated in the addict's contrived arrogance and not letting others close (brittle protectiveness), and often an excessive enthusiasm that feels disingenuous because it is often a defensive manoeuvre to protect the addict's relationship to the substance of choice while placating the treatment provider. This is commonly seen in newcomers to a

recovery group. As much as the addict might wish to give up the substance of choice, she is afraid of human relationships, which, in her mind, disappoint and frustrate. Bearing with the addict takes patience, endurance, kindness and firmness, as relapse often occurs in the early stages of recovery for this reason (Director, 2005).

4.3.5 The importance of relationship in recovery

There is a long tradition of psychoanalytic thinkers who have considered relationship as central to both the causes of and treatments for addiction. Khantzian (1999, pp. 335–356) developed the idea that addicts choose the particular substance that meets their psychological needs, challenging the stigma that addiction is rooted in self-destructiveness, weak morals, sociopathy or hedonism. Other theorists have held that drug use is an attempt to cope with and regulate emotions, and that treatment must stem from such an understanding. In addition to attending to its function as a coping mechanism, psychoanalysts have suggested possible psychodynamics and developmental influences that predispose some people to become addicted to substances.

As psychoanalytic literature has focused increasingly on attachment and its sequalae, rather than merely on intra-psychic development, the corollaries between substance use and interpersonal relations have become increasingly central to treatment. Treatment with a relational focus is thus optimal.

Group work has been considered particularly effective in addressing the issues of self-regulation and the suffering found at the core of addictive disorders, providing both relief as well as insight into individuals and their psychological issues (Khantzian, 2001). A group experience which targets both the defences and pain of the addict in a semi-structured, safe way was advocated by Khantzian (Khantzian, 2001). In such a context, an addict learns to understand how and why he has become dependent on his substance of choice, often by learning from others further down the road of recovery and then applying what he has learnt. He learns constructive alternatives to regulate his emotions and make relationships with others through the group rather than his addictive default to his substance of choice.

4.6 CONCLUSION

The psychoanalytic and communities of practice theories discussed in this chapter emphasise the importance of relationship to recovery — both in a group (social) and individual context. In particular, they emphasise the notion of identity development through relationship. As Phillips (1994) noted regarding the challenge of the addict in recovery: "Hell is not other people, but one's need for other people" (Phillips, 1994, p. 45). Learning to open up to and eventually trust others is an intimidating undertaking. The group with its practice of recovery is an ideal ground for this.

Communities of practice, as a social learning theory, provides tools to understand participants' transformation via participation in the community of practice, where the primary unit of analysis is the community of practice and not the individual participants comprising it. Linked to identity, this theory places the negotiation of meaning within the practice at the heart of human learning, rather than the acquisition of skills and information. Practice is a source of stability and coherence in a community.

By understanding the recovery group, which is the focus of this study, as a community of practice, where participants learn and teach each other and, through their individual commitment, transform, we see how social learning is the shaping of individual identity into a meaningful way of being.

Building on the exploration of the importance of supportive structures after clinical treatment (Chapter 2) and the efficacy of group work (Chapter 3), this chapter has laid the theoretical foundation for this study of the mechanisms in the recovery group, which facilitate personal transformation. The following chapter presents the methodology of the study.

CHAPTER 5
RESEARCH DESIGN AND METHODOLOGY

5.1 INTRODUCTION

The previous chapter explored aspects of identity development through the theories of communities of practice and psychoanalytic literature, including attachment theory, showing how the quality of early relationship can contribute to vulnerability to addiction and how relationship can help heal and overcome this through the social learning that occurs in a group process.

This chapter presents the research design and methodology of this study, beginning with the motivations for the study and formulation of research questions, the positioning of the study within theoretical approaches, and the methodologies which informed this study as an interpretive, qualitative case study utilising the bricolage approach. Key characteristics of the participants which relate to their recovery capital are discussed. The advantages and disadvantages of my positionality as both co-facilitator of the recovery group which was the focus of the study and researcher interacting with research participants drawn from the recovery group are discussed, along with the special ethical considerations which arose because of this. This chapter also presents the measures that were taken to ensure the quality of the study and the potential limitations which should be considered.

5.2 MOTIVATION FOR THE STUDY

Having worked with this addiction group twice a week since 2011, I had found it a great privilege to learn from the participants and addiction counsellors as I watched regular group participants transform from individuals who often displayed deceptive and destructive behaviours and expressed a sense of hopelessness become individuals who conducted themselves with honesty and accountability, and experienced a feeling of vitality.

Having worked for many years in the field of personal change, this transformation fascinated me. I wanted to better understand what it was about the group that facilitated this profound change. To this end, in 2014 I embarked upon my PhD, registered in the

discipline of education with an aim to conduct an interdisciplinary study with the benefits of both psychological and educational perspectives. I had observed that participation in the group both assisted in the maintenance of the participants' recoveries while providing the tools and provisions for them to work towards achieving their goals of living a healthier and better life. As a psychologist experienced in group therapy, I wanted to account for the group processes and mechanisms that facilitate individual transformation through an educational — and, specifically, a social learning — lens, hoping to better understand this phenomenon and thus make a contribution to knowledge in this area.

I was aware that my dual role as a group facilitator and PhD researcher might present problems. This dual role is discussed later in this chapter.

5.3 RESEARCH QUESTIONS

The primary research question this study investigated was:

> How do regular participants in the addiction recovery group learn to recover?

This question was investigated through three sub-questions:

1. What in, or about, the group assists regular participants to sustain their recoveries?
2. What pedagogic mechanisms are used in the group?
3. What knowledge helps participants sustain their recoveries and what knowledge is useful to them in the maintenance of recovery?

5.4 THEORETICAL APPROACH

5.4.1 Interpretive paradigm

Ontology refers to the nature of the reality that is being studied (Hudson & Ozanne, 1988), while epistemology refers to the way knowledge is constructed; research methodology refers to the methods the researcher uses to obtain knowledge about this reality (Carson et al., 2001; Terre Blanche et al., 2006, 2014). As the researcher, my aim was to reveal

how people who struggle with addiction — arguably amongst the most destructive states of being — through regular participation in an addiction recovery group could emerge as transformed human beings a year later. I wanted to document their own account of how they thought this was possible and how they learned to recover. To achieve this, a close focus on the experiences of the participants in the study was needed. For this, the interpretive paradigm was ideal. The interpretive paradigm involves accepting people's subjective experiences as the essence of what is real for them (ontology); making sense of their experiences by interacting with them and listening carefully to what they say (epistemology); and using qualitative research techniques to collect and analyse this information (methodology) (Terre Blanche et al., 2006). Interpreting participants' experiences in the light of the research questions is at the core of this approach.

Paradigms are the worldviews or belief systems that determine how one sees and comes to understand the world (Bassey, 1999; Terre Blanche et al., 2006). In the context of research, Bassey (1999) describes a research paradigm as "a network of coherent ideas about the nature of the world and of the functions of researchers which, adhered to by a group of researchers, conditions the patterns of their thinking and underpins their research actions" (p. 142). A paradigm works like a lens in that it influences one's perceptions and understanding of the nature of the world, and the way one relates to it and generates knowledge about it.

The interpretive paradigm was well suited to this study as it supports personal and flexible research structures (Bassey, 1999) which are receptive to capturing and honouring the meanings in human interaction (Carson et al., 2001) in order to make sense of what their subjects perceive as reality (Black, 2006). This was essential to me — to ensure that the voices of recovery in the group be heard. The interpretive paradigm views the researcher and her informants as interdependent and mutually interactive (Carson et al., 2001) — which was ideal for this study, given that I served as a co-facilitator in the recovery group to which the research participants belonged. In addition, the interpretivist researcher enters the field with some prior insight into the research context while at the same time assuming that this does not provide an adequate basis for developing a fixed research design, due to the complex and unpredictable nature of reality (Hudson & Ozanne, 1988). This closely aligned with my own experience, having facilitated this recovery group for

three years before beginning to research it, and having been trained in psychology and having facilitated many groups previously.

The interpretive paradigm requires the researcher to remain open to new knowledge throughout the study and allows new understandings to develop with the help of the research participants. This emergent and collaborative approach is grounded in the view that humans have the ability to adapt and that no one can gain prior knowledge of time and context-bound social realities (Hudson & Ozanne, 1988). This approach was congruent with my wish to impose as little as possible on the research context and rather allow the phenomenon to emerge throughout the research process. I did not assume that I could predict the findings of the research based on my past work with this group or other experiences over the course of my professional career, and I respected the idea that meaning is subjective and is bound up with the specific context and time in which it emerges.

5.4.2 Qualitative approach

The qualitative approach is well suited to research conducted from the interpretive paradigm. The intention in qualitative research is to explore the "meaning individuals or groups ascribe to a social or human problem" (Neuman, 2000, p. 44), thus gaining an in-depth and holistic understanding of the phenomenon being studied. Phenomena are studied in their natural settings and interpreted in terms of the meanings ascribed to them (Creswell, 2013) by the individuals who are involved with the phenomenon under research. Thus, "interpretation begins from the inside, rather than being imposed from outside" (Denzin & Lincoln, 2011, p. 15). In addition, the data collected are those of the participants experiencing the research phenomenon.

Qualitative research is congruent with the principles of social constructivism, where truth is seen as relative and dependent on one's perspective (Creswell, 2013). The learning of recovery, which is germane to this study, falls within a social constructivist orientation: the role of the addicts-as-learners in constructing their knowledge and transforming themselves through participating in the group is crucial and cannot be considered separately from their social context — namely, the group. Social learning theory

emphasises the importance of the learners' viewpoint in achieving an accurate understanding of the phenomenon.

The intention in qualitative research is to gain a thorough, holistic understanding of the phenomenon being studied through exploring "the meaning individuals or groups ascribe to a social or human problem" (Terre Blanche et al., 2006, p. 272). Participants themselves thus define the social reality, which must be examined from their perspectives. Cohen et al. (2011) hold that the interpretivist perspective is ideal when the reality to be studied is people's experiences and when an attempt is made to explore and explain the meanings behind these experiences. In this study, the participants were the ones who had lived and experienced personal transformations through participation in a recovery group and who were maintaining their recoveries; according to the interpretivist paradigm, they were thus deemed knowledgeable of their own experience. The role of the researcher is to faithfully and respectfully understand the meaning ascribed by participants to their experience and theorise it.

The qualitative approach resonated with my vision for the research, as I wanted the latitude to be able to capture 'outlying' experiences reported by participants without needing to make them 'fit', and to pursue in depth interesting points raised by the participants without being constrained by a quantitative approach. A qualitative approach also provided space for me to explore my positionality as facilitator and researcher as part of the study. This approach thus seemed optimally suited to the task of revealing the learning of recovery that occurred in the group process.

5.4.3 The case study

Within the qualitative approach, I considered a case study research design to be ideal for this study because of its capacity to produce in-depth understandings of the phenomenon through rich and contextualised descriptions. Case studies strive to portray what being in a specific situation is like (Terre Blanche et al., 2006): the lived experiences of, and "thoughts and feelings about, a situation" (Geertz, 1973, p. 182). The concept of a case study does justice to the participants' different and shared experiences, while uncovering the various mechanisms of group recovery from addiction.

Case study research is suggested to lead to both descriptive and analytical accounts of such phenomena (Cohen et al., 2000). That was ideal for what I needed: a methodology that provided "a systematic and in-depth investigation of a particular instance in its context in order to generate knowledge" (Rule & John, 2011, p. 4) and the study of a bounded system (Smith, in Davison et al., 2000).

Case studies are studies of a single instance or unit. In the present study, the unit was a single addiction recovery group. This worked well with the notion that case study is the examination of an instance in action (MacDonald & Walker, in Davison et al., 2000, p. 24). As my search of the literature found no previous case study looking at the pedagogic mechanisms of an addiction recovery group, I was excited about the prospect of contributing new knowledge in this area. This case study was also an instrumental case study as it was conducted to provide a "general understanding of a phenomenon using a particular case" (Harling, 2012, p. 2).

A case study investigates the relationships between the various elements that comprise the case (Sturman, 1994, cited by Cohen et al., 2011; Davison et al., 2000) while also understanding that the case is an integrated system (Stake, in Bassey, 1999). The purpose of such observation is to probe deeply and to analyse intensively the multiple phenomena that constitute the various aspects of the unit (Rule & John, 2011). This was appropriate to the study of the mechanisms of the addiction recovery group.

Case study methodology has also been used to investigate a contemporary phenomenon within its real-life context, especially when the "boundaries between phenomenon and context are not clearly evident" (Davison et al., 2000, p. 13). This conceptualisation was useful, as I was not sure what the mechanisms within the group were that were responsible for participants' learning how to overcome their addictions, and so the study entailed exploring unknown aspects within the defined boundaries of a single case. The implications of these conceptualisations emphasise the notion of interconnectedness (of parts), the study of a singularity, the idea or purpose of finding patterns within the case itself, and the notion of potentially generalisable relationships or enduring truths. As the findings emerged, the relevance of these aspects of case study research became more evident.

At the same time, the fact that the case is approached and studied as a whole — or system — appealed to me as a researcher. Such an epistemological position — a feature of both the interpretivist and critical paradigms — is fundamental to the case study of an addiction recovery group, where temporal and spatial boundaries are set and where an understanding of the relationships between the different parts and stakeholders of the project is necessary for a fuller understanding of the case (Neuman, 2000). Within the recovery group as a case, then, the pedagogic relationships between facilitators and group participants, as well as the role of newcomers and old-timers, are important.

Rule and John discuss various applications of the term "case study" (Rule & John, 2015). The following are relevant to this study: the process of conducting a case study (studying the case), the unit of study (the addiction recovery group) and the product of this type of investigation (the final written document in which the account of individual transformation via the learning of group recovery and its mechanisms is given).

According to Merriam (1998), case study methodology is used increasingly in education, law and medicine. Examples of this include works by Griffiths (2010), John (2009), Malliarakis (2015), Thompson (2005), Van Gordon, Shonin and Griffiths (2016), and Voigt (2013). Case study research on addiction (not recovery) in South Africa includes work by Breet and Bantjes (2017) and Prinsloo (2009). There does not seem to have been any case study done on recovery from addiction in South Africa. This work will make a contribution here.

Case study design is based on the recognition that "context is a powerful determinant of both causes and effects, and that in-depth understanding is required to do justice to the case" (Raw et al., 2010, p. 289). In this case, this is the first case of this phenomenon that I could find done in South Africa, and so accounting for the multicultural and varying socioeconomic context in South Africa is a new contribution both to group work and to the work of addiction recovery research.

A strength of the case study approach is the close collaboration between the researcher and participants, whereby participants describe their views of reality and thus enable the researcher to better understand their actions (Cohen et al., 2011). This collaboration is a key component of this work, and the dual role which I played as both psychologist/group co-facilitator and researcher is an aspect of this study that resulted in issues of

positionality and potential bias which had to be addressed. This positionality is another aspect of the study which makes a unique contribution to research conducted in South Africa, as I have been unable to find research on a psychologist's account of the dual role and insider research position done locally or with an addiction recovery group.

For Yin (2009), the case study is considered an appropriate research design when the research questions are largely explanatory (focusing on how and why the phenomenon manifests); when the investigator does not control behaviour; and when the focus is on a current set of events and phenomenon. This is well suited to research on how and why the addict is able to transform herself through regularly attending an addiction recovery group.

Case studies are used for many purposes, of which the following are relevant to this study:

- to generate an understanding of and insight into a particular instance through rich description, illuminating its relationships with broader contexts (the experience of social learning of addiction recovery);
- to explore a general issue within a limited and focused setting (group recovery from addiction);
- to generate theoretical insights or develop and test existing theory (linked to the theories selected — specifically communities of practice);
- to "shed light on similar cases and provide a level of generalisation or transferability" (Baxter & Jack, 2008, p. 7) (links with other mutual aid and recovery research).

A possible advantage of case studies that may especially appeal to educational researchers is that — although distinct from action research — case studies can be seen as "a step to action", in that they "begin in a world of action and contribute to it. Their insights may be directly interpreted and put to use; for staff and individual development, for within-institutional feedback; for formative evaluation …" (Rule & John, 2011, p. 292).

This point reflects my own professional interest in my research topic and was the initial reason that drew me to this work — to add, ultimately, to my practical skills, theoretical understanding and insight as a psychologist, and thus work more effectively. It was therefore enriching for me professionally to engage concurrently with theory, praxis and research.

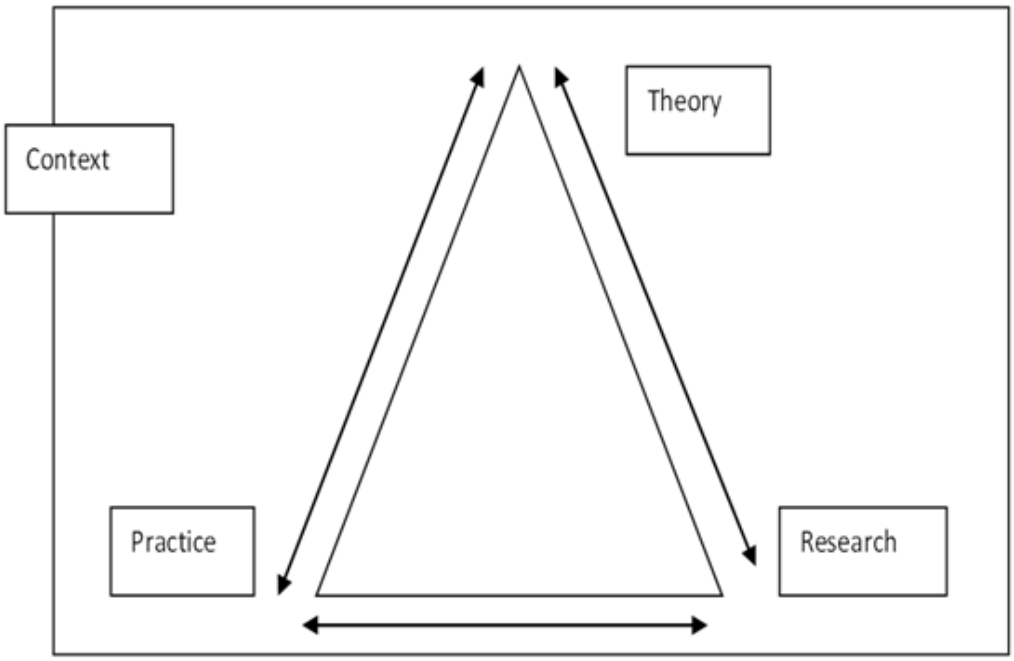


Figure 5.1 Relating theory, practice, and research (Rule & John, 2015, p. 3)

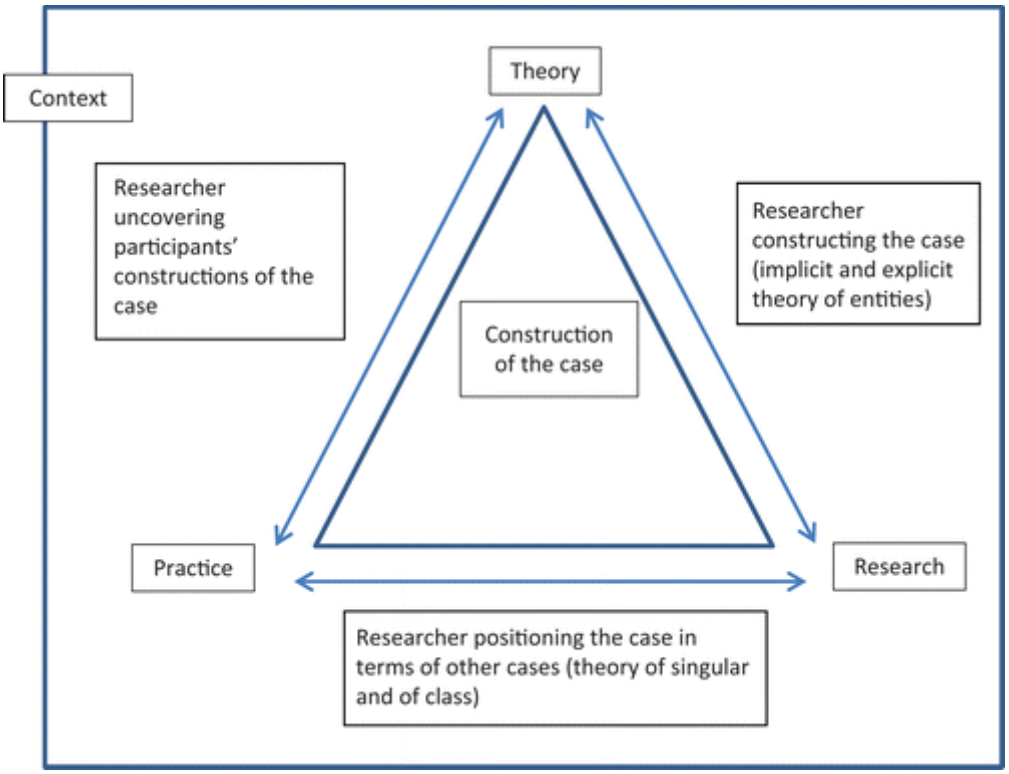


Figure 5.2 Constructing ‘‘the case’’ in case study research (Rule & John, 2015, p. 5)

It can be seen, when looking at the diagrams in Figure 5.1 and Figure 5.2, that it is an easy and elegant move from the dynamic of the practice-theory-research model (practice as psychologist — theorise practice and research the recovery group) to the case study model, which has the practice-theory-research model as its base. This fits with the fact that this study falls within my own professional practice and is thus socially situated.

The concept of 'social situatedness' was first posited by Vygotsky (1962) and 'situatedness' in terms of social learning was developed by Lave and Wenger (1991). When combined, the term refers to the development of individual intelligence which requires both social and cultural influences, as well as the multiple viewpoints held by those in the specific context (Costley, 2010). Situatedness arises from the interplay between the researcher, the situation, one's positionality and the context. The situatedness of the case in context — a South African addiction recovery group, as researched by one of its facilitators — is part of the contribution to new knowledge of this study.

Case studies have been critiqued for being idiographic and having limited generalisability (Costley et al., 2010; Rule & John, 2011). However, case studies can arguably allow for analytic generalisability (as opposed to statistical generalisability, which requires a representative sample from which findings may be generalised to the broader population). Analytic generalisability refers to a case's ability to contribute to the expansion and generalisation of theory (Silverman, 2011) which can enhance researchers' understanding of similar cases, phenomena or situations: "there is a logical rather than statistical connection between the case and the wider theory" (Yin, 2003, p. 294). Thus, it is possible that findings from the proposed case study, though particular to its context, could have wider resonance (Cohen et al., 2011). As Rule and John (2015, p. 3) explain, one researches "the one" and finds "the One" — though obviously one needs to be mindful of one's extrapolations.

While these definitions and descriptions indicate that a case study can be a study of a singularity, a number of the definitions refer to the idea or purpose of finding patterns, generalisable relationships or enduring truths. Not all writers believe that generalisable results are a necessary outcome of case study research. Those who hold the view that case study findings must be or should be generalisable tend to lean towards the post-positivist paradigm.

Findings from this study which relate to common aspects of recovery groups (such as mutual aid, the nature of membership and mutual accountability), the aspects of transformation within a person (psychological, physical and spiritual), the specific emotional aspects which are transformed through recovery from addiction, as well as the underlying importance of empathy and mentalisation, may have broader application. Nonetheless, the intention is not to make claims beyond the case. My choice of methodology was guided by the 'fit for purpose' principle — it was "a considered choice to study the singular with the explicit intention of gaining understanding of the particularity of the case" (Rule & John, 2011, p. 105).

A strength of the case study methodology is that it can offer a rich store of information about a phenomenon by providing a global, multi-dimensional picture of it through the mindful "exercise of creativity, critical discernment, and sensitivity to local contexts" (Rule & John, 2015, p. 10) — which is what this research aims to achieve.

In the present study, as part of the case study it was considered important to be open to data which emerged from both collection and analysis, but to equally remain open to the emergence of theory from the data. This is using the content analysis approach and phenomenological premise of letting the phenomenon speak for itself as far as possible and making my own assumptions and biases as explicit as possible. No hypothesis (quantitative in nature) or theoretical proposition was declared prior to this study for the above reasons.

The dialogical approach to case study research as proposed by Rule and John (2015) is a recursive process with a constant to and fro between theory and research at various stages of the research, where theory and research are considered mutually constitutive and play their parts in the creation of the new contribution to knowledge. The dimensions of dialogue in case study research in this particular case study are the dialogue between the 'case' (the recovery group) and the 'study' (social learning of recovery as well as personal transformation through a group process). This was executed by examining what was being studied factually in the case, as well as the qualitative aspects of the group. The researcher's positionality is key as is the dialogue between the 'one' (the specific case of an addiction recovery group) and 'the One' (mechanisms in an addiction recovery group that support and maintain personal transformation from addiction).

5.4.4 The bricolage approach

The case study approach dovetails with the bricolage approach described by Norman Denzin and Yvonne Lincoln (Denzin & Lincoln, 2011), and highlights the recognition of the dialectical nature of the disciplinary and interdisciplinary relationship, and the synergy between both aspects of the work.

Bricolage is used as a way of integrating emerging master themes with theory and literature cohesively, bearing in mind the interdisciplinary and diverse aspects of the work (Freeman, 2007; Warne & McAndrew, 2009). Bricolage is particularly suitable, as an approach, for practitioners within health, social care and education — especially those studying part time at doctoral level (such as myself). The emergent nature of bricolage allows for bite-size chunks of research to be done that have individual meaning for practice, which can then be pieced together to create a more meaningful whole (Wibberley, 2012). It has also been suggested that many health practitioners develop practice knowledge through bricolage. This suggested a stained-glass work — where the glass is both the phenomenon and the lens through which one looks at the phenomenon (Wibberley, 2017). I liked the inadvertent pun which 'glass' provides — the glass referring to both stained glass and to the glass holding alcohol.

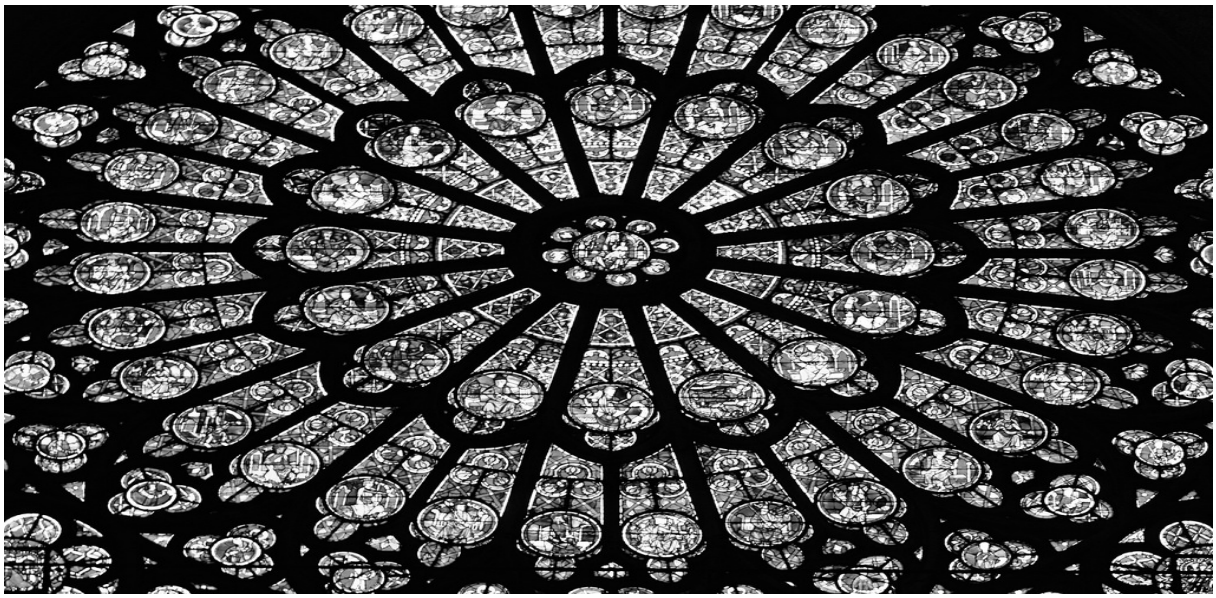


Figure 5.3 Stained glass of Notre Dame de Paris, 2012, https://www.flickr.com/photos/serlunar/8126438679

I was particularly inspired by the notion that the "fragments of data can be thought of as either being drawn into an ordered whole (stained glass) or left disjointed and jarring against each other (smashed glass)" (Wibberley, 2012, p. 6). This was salient in terms of this interdisciplinary study: in this case and context, bricolage emphasises the diverse understandings and knowledge emergent in the act of interdisciplinary research — highlighting the complexities of the research act itself. It hopes to contribute an enriched knowledge and "avoids both the superficiality of methodological breadth and the parochialism of a unidisciplinary approach" (Denzin & Lincoln, 2011, p. 4). To be able to employ a variety of different lenses and disciplines (psychology, group therapy, addiction, pedagogy, social learning theory — specifically, communities of practice) in a way that enhanced this, presented a refreshing and exciting opportunity to strive to contribute new knowledge using this approach. specific example being Yalom's curative factors

From a bricolage perspective, I moved continually from my data, to master theme, to literature, to conceptualising and contextualising the theme. In my mind, I had the image of the 'bricoleur' — the person who creates with whatever materials are at hand — and so, with all of the above, I felt like I was manifesting a creative and organic account of the phenomenon.

The learning aspect was important because I wanted to view the addicts with a non-pathological lens (different from psychology). I wanted to see my participants as I see all people — as individuals struggling with being human. The bricolage notion of different shapes and colours of panes making up the larger whole of the stained-glass window abided with me through this process, while each separate segment was unique unto itself as well, yet part of the greater whole.

5.5 RESEARCH DESIGN

The unit of analysis was the specific aftercare addiction recovery group at a private clinic in KwaZulu-Natal, South Africa. The objectives were to understand what mechanisms existed in this particular group that facilitated and maintained the recovery of regular participants. The main theory used was communities of practice, supplemented by the self-medication hypothesis and attachment theory, which have roots in psychoanalysis.

Sources of information were the voluntary regular participants of this particular group, as well as its addiction counsellors, who assisted in the co-facilitation of the group. Data collection was in the form of individual semi-structured interviews and focus groups. The method of data analysis used was thematic analysis combined with interpretative phenomenological analysis (IPA), because of its idiographic focus.

5.5.1 Selection and characteristics of research site and participants

This case study involved a specific addiction aftercare recovery group. It was selected because I had been the psychologist and co-facilitator of the group. The group had been started in 2011 for patients who had been through the addiction inpatient rehabilitation programme at a private clinic in a city in KwaZulu-Natal and met at the clinic for an hour, twice a week. The group was co-facilitated by a psychologist (myself) and three separate, consecutive addiction counsellors (addicts who had been in unbroken recovery for three or more years). While I co-facilitated this particular group from August 2011 until July 2016, the research was undertaken from February 2015 until November 2017.

Most of the data collection happened on the premises of the clinic as participants were comfortable and related well to that setting. The clinic was a physical embodiment of much of their recovery history and early memories of recovery, as well as the aftercare group itself. The meaning of the setting of the interviews felt important for this reason.

Each meeting comprised of about 20 members, both inpatients who were required to attend and outpatients who chose to attend the group. The composition of the group reflected the diversity of South Africa's population and of the population suffering from addiction, representing a range of races, cultures, classes and genders. The demographics of the participants in the study do not reflect the demographics of the recovery group from which the participants were drawn, however. The recovery group contained more isiZulu speakers, women and younger people; however, very few had reached the milestone of a year in recovery within the group in question, which was a criterion for participation in the study. The participants in the study consisted primarily of older, white, educated men with serious addictions — mostly to alcohol. This profile is consistent with that in much of the literature on twelve-step groups reviewed earlier; despite it being largely American research, aspects of addiction are consistent across both populations.

Selection of participants. This study made use of purposive sampling: a defined sample of participants in a particular aftercare recovery group who were prepared to participate in research on how they learned to recover from their addiction via attending the group in question, was selected. The advantage of using this sampling method lay in its ability to identify key participants, a requirement of this study. All those who met the criteria were included as study participants. The inclusion criteria for participants were as follows:

- Participants needed to be outpatient participants of the addiction aftercare group who had gone through rehabilitation at the clinic in question.
- Participants needed to have been diagnosed with substance use disorder by a medical professional.
- Participants needed to have a substance as their primary addiction. This is because behavioural addictions may have different aspects to their recovery. This study only aims at exploring substance addiction recovery. However, a sex addict was used in the pilot interview as he had experience of group recovery via another recovery group. It transpired that the quality of his responses was so good that he was included in the write-up.
- Participants needed to be over 18 years of age in order to consent.
- Participants needed to be involved in an additional supportive therapeutic context to the group in question, e.g. a support group, or individual psychotherapy.
- Participants did not have to be English first-language speakers. Translators would be provided if needed.
- Participants needed to be able and willing to sign informed consent to participate in the study.

Inclusion was restricted to participants over 18 so that parental consent would not be required. The selection of participants who were in psychotherapy or attending a support group served a dual purpose: firstly, they were likely to already be engaged in reflection about their recovery, and secondly, they would have additional psychological support if needed. There was no requirement regarding the participants' gender, culture or ethnic group.

While translators were offered to English second-language speakers, no participants took up this offer. Participants were offered copies of their interviews in both audio and text formats, and were given the opportunity to redact anything they may have felt uncomfortable about. Only one took up the offer to have a copy of his interview. He did not change anything. They were also offered the option of another (unknown) interviewer; this was not taken up. I suggest that this was because they trusted me and were comfortable with me.

5.5.2 Informed consent and confidentiality

All of the participants selected for this study were over the age of 18 and were deemed mentally and psychologically capable of providing consent. I explained repeatedly that their participation was completely voluntary and optional: they were free to choose to not participate; if they did choose to participate, they were free to withdraw at any time. None of the participants withdrew during the study, though over time fewer people chose to participate in the focus groups.

Secondly, all participants signed consent for me to audio-record their responses in the individual interviews and in the focus groups. I explained to them that if they were not comfortable consenting to this, I was prepared to take notes instead.

Thirdly, I explained that they would not be paid for their participation in the study. I did provide drinks and snacks at all interviews, and paid the transport costs of participants who requested this.

Fourthly, it was key that participants were capable of distinguishing between my roles as facilitator of their recovery group and researcher in the study, and their roles as participants in the recovery group and participants in the research study. This was discussed with them at every stage of the study and all demonstrated that they were able to make the distinction. I continually reminded that their participation in the study was not for their personal benefit but as a contribution to my research.

Fifthly, and finally, the meaning and importance of confidentiality was discussed and accepted by all study participants. The participants were familiar with confidentiality as one of the ground rules of the recovery group. At each focus group, confidentiality was

discussed again and mutually agreed, so that anything raised in that focus group would not leave the focus group unless it was with permission. It was explicitly stated that the focus group was not part of the recovery group.

Confidentiality was also maintained by my redacting the participants' real names and changing them. They were given the option of choosing names, which some of them did. One chose the name they would give to a child had they had one. As far as possible, I tried to keep the names consistent with the cultural group of the participant. I also ensured when compiling biographical information that it was detailed enough to be useful but did not include details which could reveal the identities of the participants.

The data elicited came from eight individual interviews and five different focus groups. The interviews were coded as they were done, which led myself and my supervisor to agree that there was data saturation at the end of the eighth interview. The focus group topics were shared with participants who were free to choose which they wanted to participate in. Each group was different. There were nineteen participants in this study.

5.5.3 Demographic characteristics of participants as recovery capital

The concept of 'recovery capital' enables the relationship of demographic characteristics to recovery to be better understood. Recovery capital refers to "the quantity and quality of internal and external resources that one can bring to bear to initiate and sustain recovery from addiction" (Granfield & Cloud, 2001, p. 1543). Drawing upon the earlier literature on social capital, Granfield and Cloud (2001) posited that recovery capital comprises four aspects: physical capital (e.g. income, cash, and assets); cultural capital (e.g. values, beliefs and social attitudes); human capital (e.g. education, knowledge, skills); and social capital (e.g. relationships, social standing and broader social networks). According to Cloud and Granfield (2008), people who have access to recovery capital are more likely to overcome their addictions than those who do not. They conversely also have far more to lose (Waldorf et al., 1992). Having much to lose is indicated in research to be an incentive to positively transform one's life insofar as if there is little to lose as the result of addiction, the addict may not see any point in stopping (Cloud & Granfield, 1994).

Table 5.1 provides information on the age, marital status, level of education, type of employment, race, gender and home language of each of the 19 participants in the study.

Table 5.1 Demographic characteristics of study participants (using pseudonyms)

Name	Birth decade	Marital status	Level of education	Type of work	Race	Gender	Home language
1. Vega	1970	Partner	Matric	Data capture	White	F	English
2. Rob	1970	Married	Matric	Graphic designer	Indian	M	English
3. Boet	1950	Married	Matric	Retired SAPS	White	M	Afrikaans
4. Alexis	1960	Divorced	Diploma	Nurse	White	F	English
5. Scott	1940	Married	Diploma	Lecturer, retired	White	M	English
6. Amith	1950	Widowed	Diploma	Electrician	Indian	M	English
7. Peter	1950	Married	Diploma	Groundsman	White	M	A/E
8. McKenzie	1960	Divorced	Matric	SAPS	White	M	English
9. Spero	1950	Married	University	Own business	White	M	English
10. Karen	1970	Partner	Matric	Own business	White	F	A/E
11. Bob	1970	Engaged	Matric	Caretaker	White	M	English
12. Stephen	1960	Single	Matric	Addiction counsellor	White	M	English
13. MaNoj	1970	Partner	University	Mechanical engineering	Indian	M	English
14. Jashwin	1950	Married	University	Educationalist	Indian	M	English
15. Zimo	1980	Partner	Matric	Technician, now unemployed	Zulu	M	Zulu
16. Rio	1970	Married	University	Environmental management	Indian	M	English
17. Dave	1970	Engaged	Matric	Addiction counsellor	White	M	English
18. Nikhil	1970	Married	Matric	Director	Indian	M	English
19. Mervyn	1970	Partner	Matric	SAPS	Indian	M	English

The majority of the participants in this study had some recovery capital (such as male privilege, white privilege, the dominant group language as their home language, employment, or stable relationships in the form of spouses or partners) to motivate their recovery, both in terms of having something to lose as well as having some systems of support in place for their recoveries.

Building one's recovery capital can thus be a way to enhance recovery. Many addicts attempting to recover make significant and necessary changes to their personal and professional environments and social networks in order to surround themselves with an environment that will support their recovery. This could include joining and participating regularly in an addiction recovery group.

Age. Seventeen of the nineteen participants were between approximately 40 and 60 years of age (as shown in Figure 5.4). From a developmental perspective, an older person is considered more stable and mature. This could suggest that a commitment to recovery could be kept more easily by an older person than by a younger person who has to deal with issues such as peer pressure.

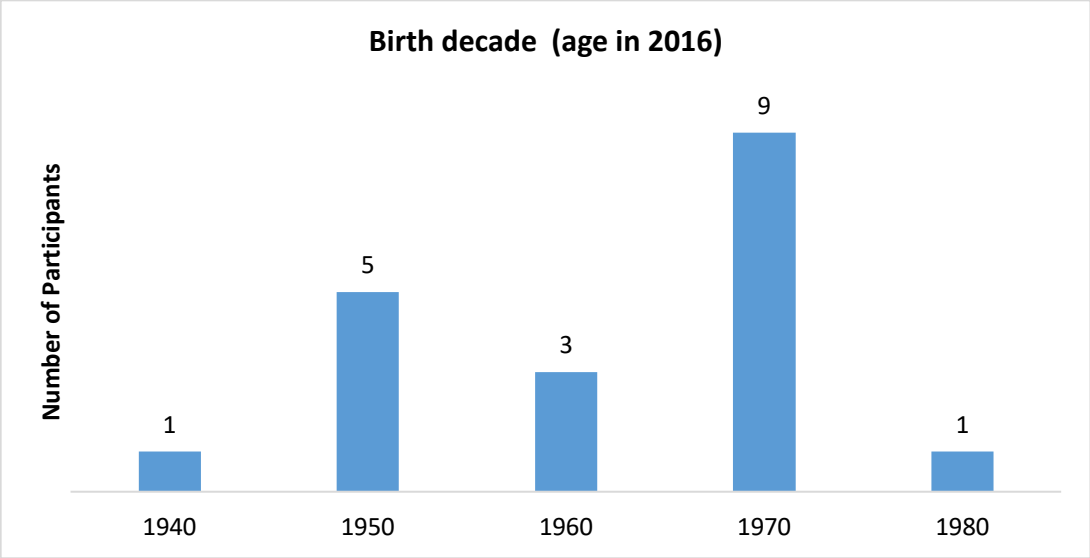


Figure 5.4 Decades in which participants were born

Intimate relationships. Fifteen of the nineteen participants were in stable relationships, as shown in Figure 5.5. They reported them to be happy. This would add significant support to recovery.

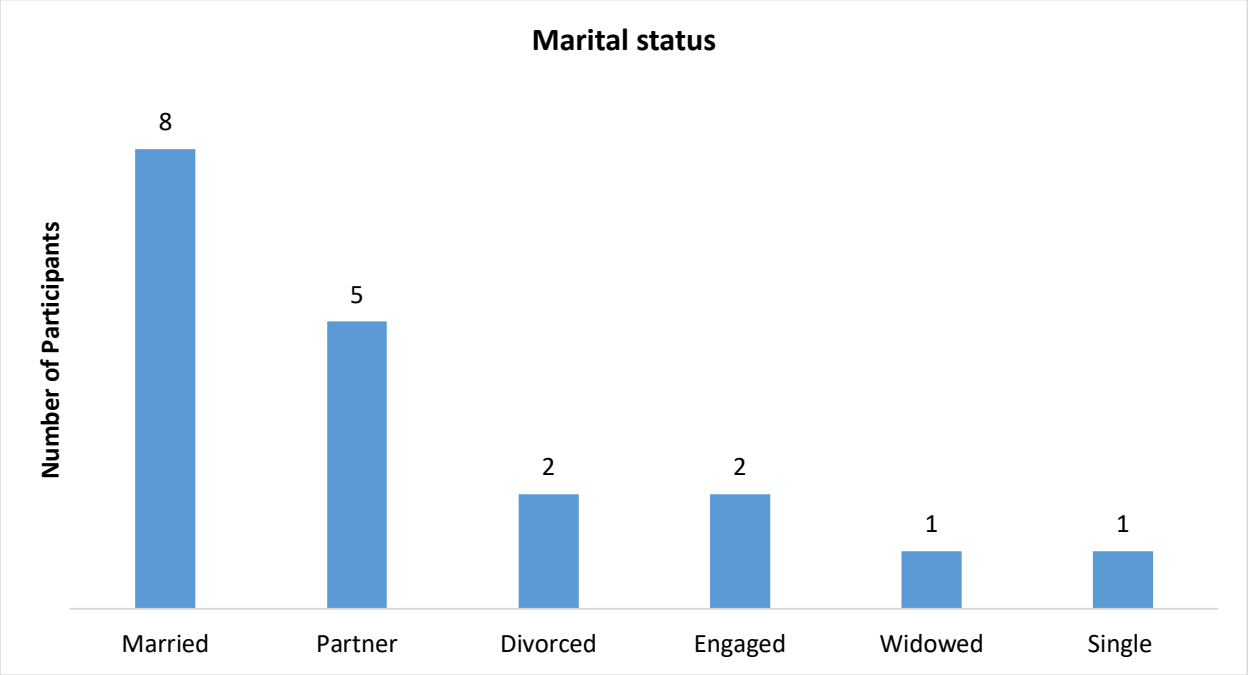


Figure 5.5 Marital status of participants

Education. As shown in Figure 5.6, all participants had at least a secondary education; eight had a tertiary education. The opportunities associated with education represent a recovery asset.

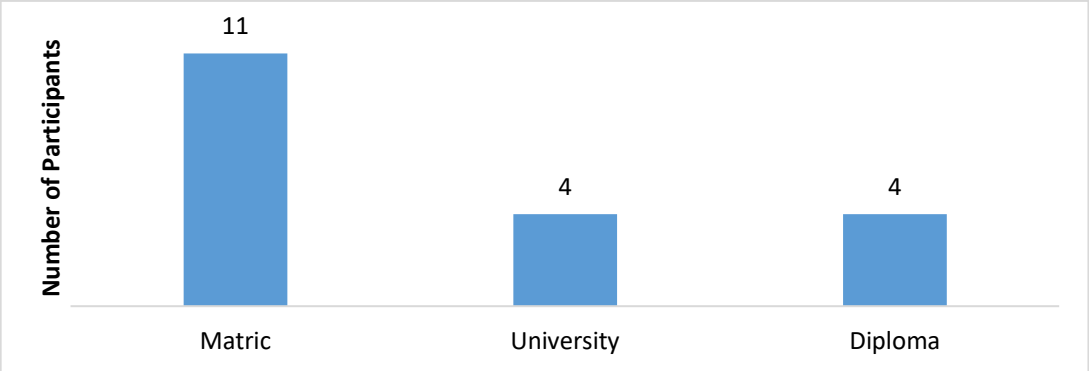


Figure 5.6 Highest level of education attained by participants

Employment. The majority of the participants (17) were gainfully employed, and two were retired. In an addicted population this is significant, as it means that they have managed to keep working despite their addictions and have work to return to after rehabilitation. Many were sent to rehab by their employers, who were aware of their addiction. Having a regular salary, something to do each day and distractions from thinking about addiction all contribute to the recovery asset represented by employment.

Race. Eleven of the nineteen participants were white, as shown in Figure 5.7. Given that most of the participants were older, white privilege arising from apartheid would have accrued in terms of their education and employment experiences, as well as their perceptions of themselves. The one Zulu participant in the group demonstrated a high level of commitment to the group, travelling a long distance to attend the meetings. He had also gone to great lengths to start a new life in his recovery, including not visiting the shebeen (tavern) his girlfriend owned. Reference was made to race from time to time in the group as a way of saying that although their races were different, the group members were bound by addiction, which made them family.

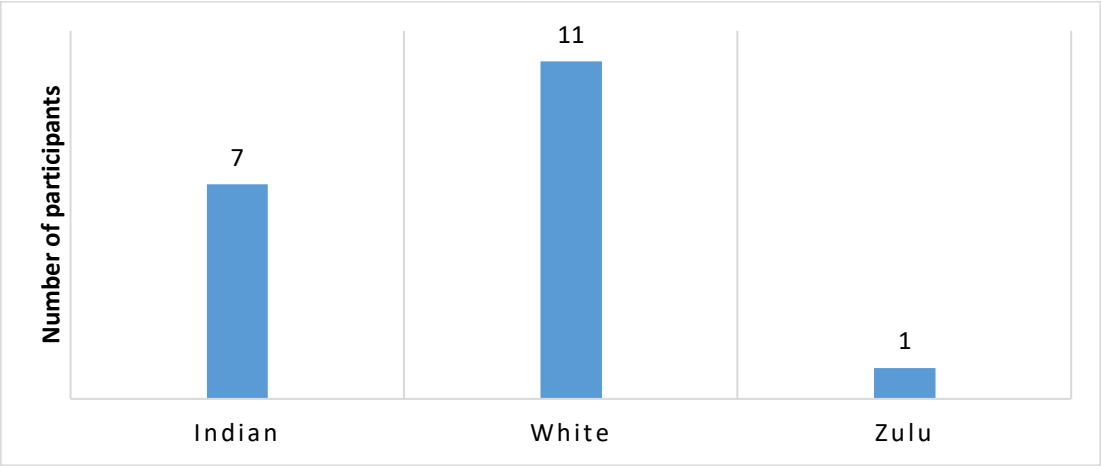


Figure 5.7 Racial identities of participants

Home language. As shown in Figure 5.8, English-language privilege was also indicated, as the group was conducted in English and so two people participated in a non-mother tongue. These study participants were asked if they would prefer a translator to translate the interview questions and focus group discussions into their language of choice, but they said they were comfortable in English.

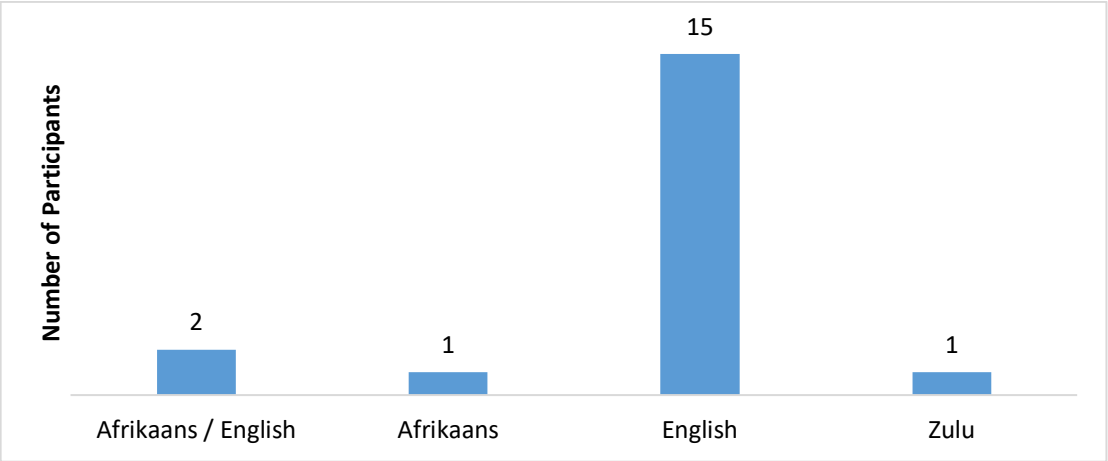


Figure 5.8 Home language of participants

Gender. The majority of the participants were male (as shown in Figure 5.9). They were extremely interested when the female participants shared about their lives — as if it gave them a vista into another world. There was a gallantry and gentleness towards the women in the group and in the study sample group, while there was a hardier bantering among the men. Perhaps because it was a mixed group, issues of sex and sexuality were seldom touched on.

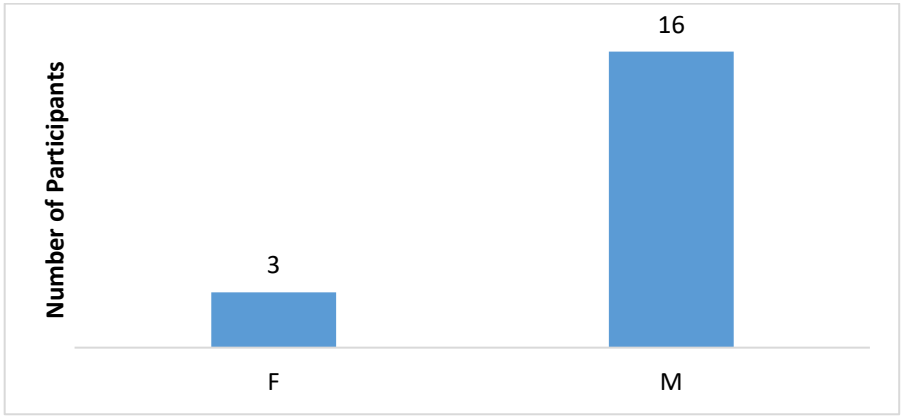


Figure 5.9 Gender of participants

Table 5.2 contains characteristics of the participants and their recoveries in order to depict a more detailed picture of both addiction and recovery.

Table 5.2 Characteristics of participants' recoveries (using pseudonyms)

Name	Longest recovery (years rounded up or down)	Years currently in recovery (years rounded up or down)	Length of time attending group (years rounded up or down)	Substances of choice	Years addicted	Previous attempts to stop
1. Rio	15	15	facilitator – 1	Cocaine, Dagga	13	3
2. Stephen	10	10	facilitator – 3	Alcohol cocaine,	30	1
3. Dave	6	6	facilitator – 2	Heroin	17	9
4. McKenzie	4	4	4	Alcohol	30	1
5. Mervyn	4	4	4	Alcohol	19	1
6. Vega	3	3	4	Codeine	4	3
7. Spero	3	3	5	Sex (not a substance)	52	many
8. Karen	3	3	3	Alcohol cocaine,	34	8
9. Jay	3	3	3	Alcohol	28	3
10. Boet	2	2	2	Alcohol	30	2
11. Amith	2	2	2	Alcohol	15	3
12. Zimo	2	2	2	Alcohol	12	many
13. Rob	1	1	1	Alcohol	29	2
14. Alexis	1	1	1	Opiates	10	1
15. Scott	1	1	1	Alcohol	40	1
16. Peter	1	1	2	Cocaine	3	3
17. Bob	1	1	1	Alcohol	20	3
18. MaNoj	1	1	1	Alcohol	4	4
19. Nikhil	1	1	1	Alcohol	25	2

Substances of choice. As shown in Figure 5.10, the majority of participants (13) were addicted to alcohol; for 11 of them, this was their only addiction, while two were co-addicted to cocaine and alcohol. One person was solely addicted to cocaine and one was addicted to cocaine and dagga. The remaining three participants were addicted solely to opioids. That most of the participants were alcoholics is representative of the fact that the addictive substance of choice in South Africa is alcohol.

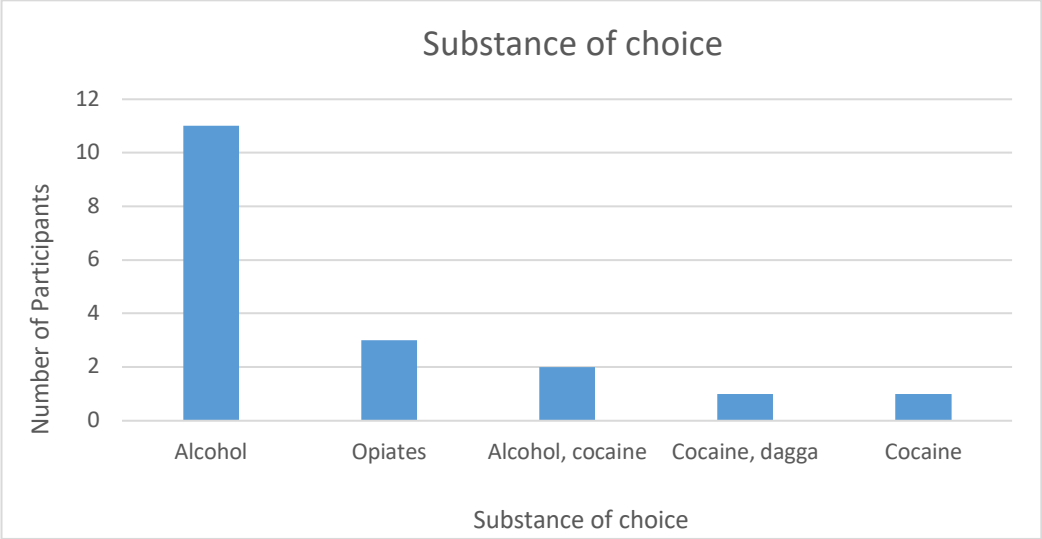


Figure 5.10 Substance of choice

Attempts to stop use of substance. Figure 5.11 shows that six participants had tried three times to stop using their substance of choice, five were on their first attempt to stop and three had tried twice before. The remainder had tried a few times, ranging from four times to over ten times. This indicates the inconsistent nature of recovery, comprised often of many attempts to stay sober and many relapses. What emerged often is how one learns to recover through making sense of one's relapses and understanding what triggered them. For most addicts in the group, it was not a straight trajectory.

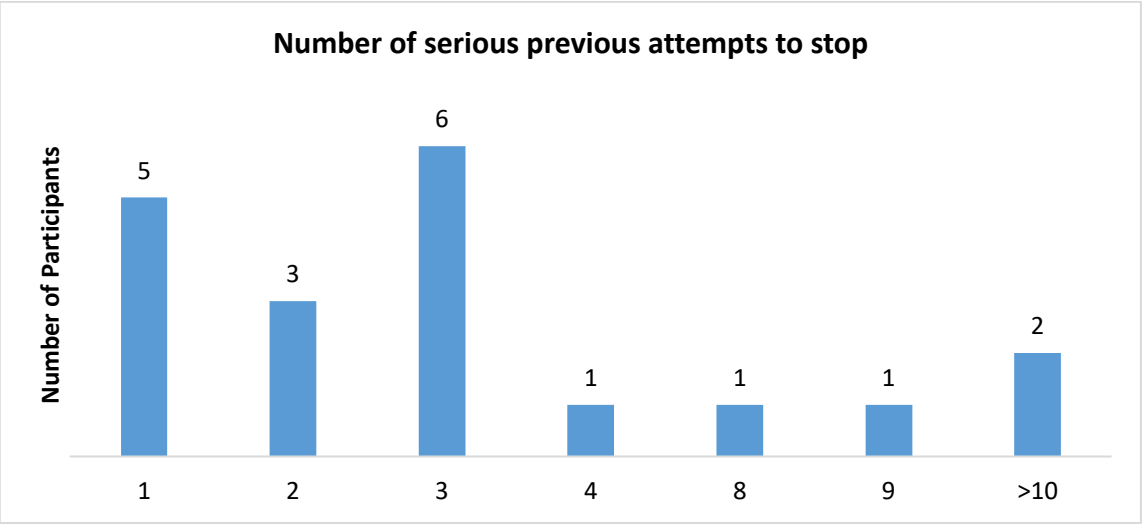


Figure 5.11 Number of serious previous attempts to stop

Length of present recovery. Figure 5.12 shows how important it is to have a combination of old-timers and newcomers when learning how to recover from addiction. Seven of the participants had been clean for a year. This was the base-line criterion for participation in this research. The remaining participants had been clean for between two and four years. The group itself was started in 2011, and the research began in 2015; therefore, five years would have been the maximum number of years sober for any of the participants, apart from the group co-facilitators, who were addiction counsellors and were also participants in this study, and who had been clean for six, ten, and fifteen years.

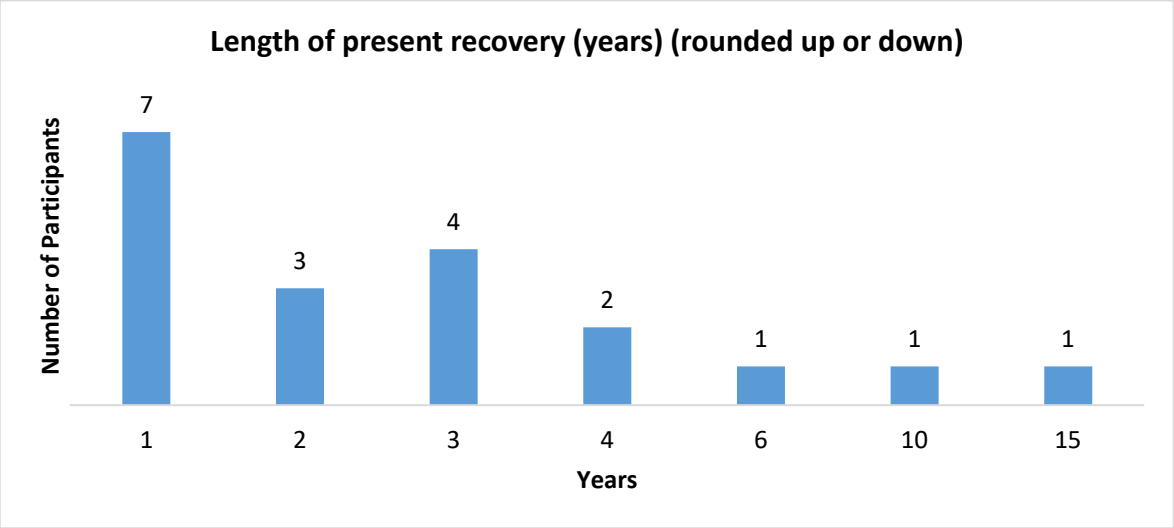


Figure 5.12 Length of present recovery

Longest recovery. Figure 5.13 ties in closely with Figure 5.12, and indicates the success of this particular recovery group insofar as most participants' longest recoveries had been achieved in the group in this study. This was another finding in the study, indicating the success of this group in comparison with previous groups and attempts of the participants. (This obviously excludes the addiction counsellors' recovery stretches of six, ten, and fifteen years.) This suggests that the findings of this study would have a validity borne out by the fact that the group is doing what it is meant to — namely, teaching and maintaining the recovery of its regular participants.

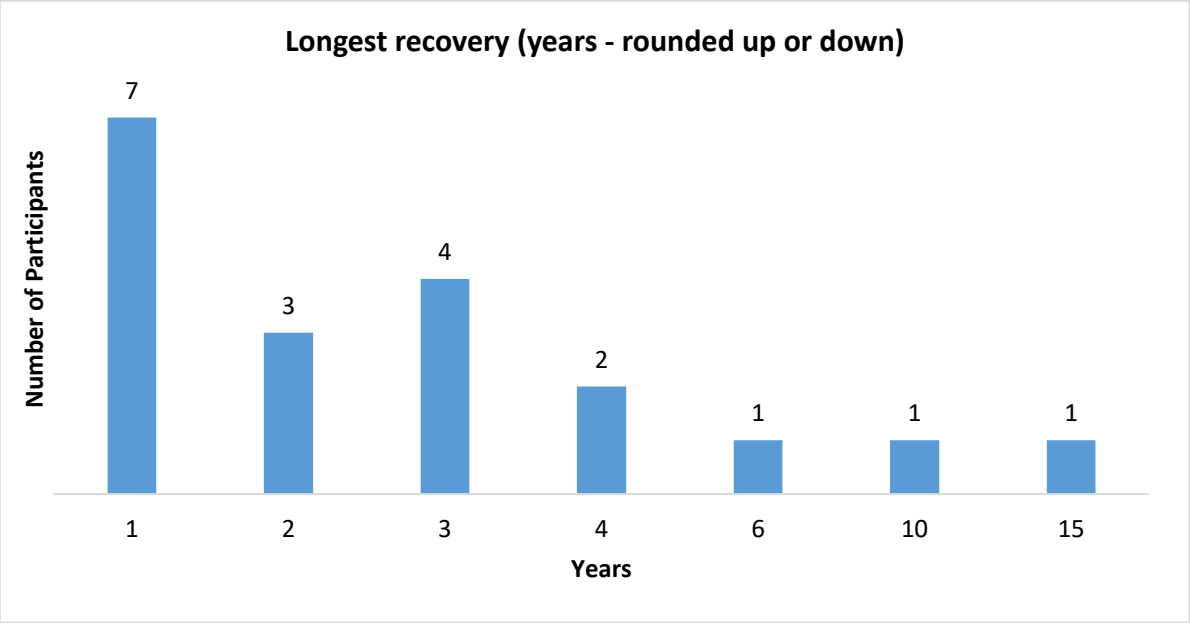


Figure 5.13 Longest recovery thus far

Duration of participation in this recovery group. As shown in Figure 5.14 below, six participants in the study had been regular members of the recovery group for a year, four for two years, two for three years, three for four years, and one for five years. These participants would have had sufficient experience of the group, its workings, and its impact on their recoveries to comment confidently on it. The remaining three people were facilitators who had facilitated for two and a half years, one year, and two years respectively, and so had a good grasp of the group as well.

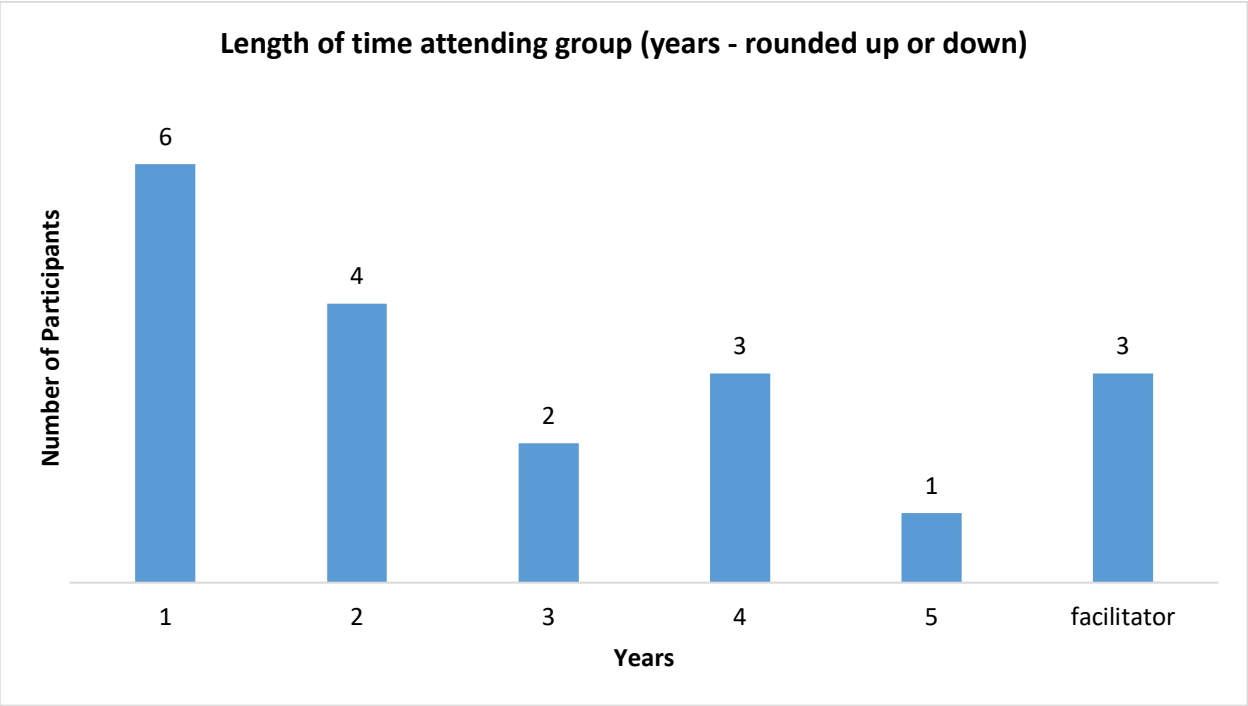


Figure 5.14 Length of time attending this group

5.6 DATA COLLECTION

The data sources comprised eight individual interviews with five group participants and three group facilitators (approximately twenty hours in total), five focus group sessions (approximately twelve hours in total), thematic analysis of three group sessions and an N-Vivo content analysis of session case notes. There were nineteen participants — three addiction counsellors who co-facilitated the group with me consecutively during the five years, and sixteen recovery group participants, one being the pilot study. In all, nineteen people were interviewed through eight individual interviews and five different focus groups, each on a different aspect of the group. A pilot interview was conducted, and five participants were interviewed individually. The data that emerged was deemed by my supervisor and me to be of sufficient richness and quality to not warrant further individual interviews. In addition, there was a sense of data saturation which confirmed this.

5.7 PARTICIPATION IN INDIVIDUAL INTERVIEWS AND FOCUS GROUPS

Table 5.3 Focus group participation

Name	Individual interview	FG 1: Repertoire of competence	FG 2: Communities of practice; pedagogy	FG 3: Wrap up	FG 4: Proof of the pudding 3 months on	FG 5: Membership & accountability competency framework
	March 2015 – Sep 2016	**16 June 2016**	**25 June 2016**	**17 July 2016**	**1 Oct 2016**	**11 Nov 2017**
		4 hours	**3 hours**	**1 hour**	**2,5 hours**	**2 hours**
1. Spero	✓ (pilot interview)					
2. Rio	✓					
3. Stephen	✓					
4. Dave	✓					
5. Mervyn?	✓					
6. Bob	✓					
7. Rob		✓				
8. MaNoj			✓			
9. McKenzie		✓				
10. Peter		✓			✓	
11. Nikhil			✓		✓	
12. Karen	✓		✓		✓	
13. Zimo	✓			✓	✓	
14. Jay			✓		✓	✓
15. Boet		✓	✓	✓	✓	
16. Amith		✓		✓	✓	
17. Alexis		✓	✓	✓	✓	
18. Scott		✓	✓	✓	✓	
19. Vega		✓	✓	✓	✓	✓
	8	**8**	**8**	**6**	**10**	**2**

5.7.1 Semi-structured interviews

During the first phase of data collection, in-depth, semi-structured individual interviews were conducted with individual participants, which ranged from two to three hours in length. All of the interviews were conducted at the clinic so that participants would feel relaxed and comfortable in the familiar context of their recovery. Only one interview was conducted at a local coffee shop at the request and convenience of the participant. The individual interviews were conducted during 2015.

I began with a pilot interview, selecting a member of another recovery group who was experienced with its processes and conscious of his own personal transformation through regular participation in that group. His addiction was sex, which, while different to a substance addiction, is nonetheless serious. He was articulate and I selected him with the hope that he would be able to reflect on the interview and give me critical feedback that would benefit the study. His interview lasted for two and a half hours. His feedback was positive: he indicated that he had benefited during and after the interview as a result of the insights he had gained in the course of responding to the interview questions. He did not give any negative feedback and did not suggest any changes to the interview process, although he did say he was tired by the end of the interview. I learned from this to take more regular breaks during subsequent interviews. I included him in my sample, as his responses were interesting and apposite, and were revelatory of the phenomenon.

Johnson (2002) describes the in-depth interview as "a face-to-face interaction between an interviewer and an informant which seeks to build the kind of intimacy that is common for .... self disclosure" (p. 99). As in-depth interviews are usually long, with the researcher building up an understanding of the participant through the natural ebb and flow of the interview process, the interviewer needs to be prepared to remain focused, and to regulate and motivate the participant throughout the interview process.

I found that although I have been interviewing people therapeutically for over thirty years, conducting the in-depth interviews proved tiring and required a tenacity which surprised me, perhaps because of the evaluative component involved in listening selectively for responses related to my research questions, rather than focusing on being therapeutically attuned to the interviewee. I found it difficult to cut the interviewee off, partly out of concern that this would inhibit them from providing more information on a sensitive topic

later. My sense was that all those interviewed in both individual and focus group settings participated openly and generously. I commented often about these various aspects of my experience of interviewing in my thesis process journal.

5.7.2 Focus group discussions

A focus group discussion is a frequently used data collection method in education and the social sciences (Henning et al., 2004) and typically involves a facilitator/researcher inviting a limited number of people (often between six and eight) to participate in a semi-structured discussion on a particular topic. The discussion is usually led by a facilitator and guided by discussion points. Recording is done for subsequent transcription and analysis purposes. In some focus groups, participants are considered experts and are invited to co-construct negotiated meaning, rather than merely answer questions (Wilkinson, 1998). This was the case in the focus groups in this study.

Focus group discussion was deemed an appropriate methodological entry into this aspect of data production for this study for two reasons. In addition to wanting to focus on an interpersonal and collective process among the participants (using a group process to research a group process), I also wanted to minimise my own dominance and bias in the research process. Although I could not avoid facilitating and leading the discussions, I anticipated that my being outnumbered in the initial data production stages could function to empower the research participants in discussion (Wilkinson, 1998). I enjoyed the group dynamic in the focus groups: the mood was less emotionally intense, and the conversation moved more quickly than in the individual interviews. While the individual interviews revealed the personal challenges faced by individuals in recovery, the focus groups explored aspects of the recovery group.

The five different focus groups were conducted on 16 June 2016, 25 June 2016, 17 July 2016, 1 October 2016 and 11 November 2017. The dates were chosen for the following reasons. I was given notice in May 2016 that my services as a consultant therapist for this particular group were to be terminated at the end of July 2016 as the clinic intended to use in-house health professionals to run recovery groups. As such, I wanted to complete as much focus group research as possible while still working at the clinic. I was astounded by the generosity of the participants in terms of their willingness to give up their time in

order to participate: eight participants participated in the first two focus groups and six in the third session — representing almost eight hours over the period of a month. The focus groups explored various aspects of communities of practice, the pedagogy of the group, framework of competencies, Regime of Competence and its development over time. After a three-month interval I held what I thought was to be the final focus group, to which I invited the participants in order to comment on the structure of the group and raise anything they wished to speak about. Ten participants attended this focus group.

Over a year later, after having transcribed, analysed and written up the data that had emerged from the interviews and focus groups, and having participated in a second online, four-day workshop with Etienne and Bev Wenger-Trayner (in July 2017), I realised that gaps still existed in my data in terms of accounting for the membership and accountability of the group's Regime of Competence. To address this, I ran a fifth and final focus group to which two participants came. This also probably indicated that I had worn out the willingness of the group members to participate further in the study.

5.8 DATA CODING AND ANALYSIS

As a psychologist, my inclination was to focus on the emotional changes in addiction recovery that emerged in the interview data and literature. I was confident that this was a strong base from which to begin the coding and analysis. When I began the coding process, I did not imagine that I would find that the identity transformation experienced by participants through participation in the group would go far beyond regulating and managing emotional states and would involve all aspects of the person. Themes emerged through the coding process and data was analysed on this thematic basis.

As a novice researcher, I wanted to use a well-established process for coding and analysis. Munro (2014, p. 20) notes: "Regardless of methodological approach, it is the precise coding that ensures the reliability of a global pattern, a theme-finding analysis or the development of a 'substantive theory'". It was envisaged that by enhancing the guidelines for thematic analysis (Braun & Clarke, 2006) with recommendations from IPA (interpretative phenomenological analysis), themes could be developed that captured the meanings attributed by participants to their experiences (Willig, 2013).

IPA has been used to explore issues in health studies, including much work on addiction (including Chappell et al., 2006; Flaherty et al., 2014; Larkin & Griffiths, 2009; Shinebourne & Smith, 2009; Shinebourne & Smith, 2011; Smith & Osborn, 2008). The understanding of knowledge as reflexive and constructed was compatible with the theoretical framework of this study. Thematic analysis recognises two processes — the emergence of participants' meaning and the co-interpretation of the researcher — which occur in a continual hermeneutic exchange between the two; knowledge is thus co-constructed and relative and emerges through a process of interpretation (Smith & Marshall, 2007, p. 65).

Smith and Osborn (2008) advised that the researcher's attitude be empathic during the initial attempt to understand participants' experiences, moving to gentle questioning and then a more critical and speculative reflection. Here, in thematic analysis, unlike other phenomenological traditions, prior knowledge is not bracketed (Willig, 2013). Priority is given to the participants' accounts before any theorising or contextualising in the literature is done (Chappell et al., 2006; Green et al., 2007; Smith, 2004). The final product should instil new insight into the participants' experience of the phenomenon (Larkin et al., 2006), where the reader's appreciation of the phenomenon is enhanced (Elliot et al., 1999).

Willig (2013) cautions against stopping the method prematurely and encourages it to be followed through all of its stages.

The steps recommended by proponents of thematic analysis (Braun & Clarke, 2006) and IPA (Smith & Osborn, 2008; Willig, 2013) were summarised and amalgamated into a new set of steps. These consisted of overlap, despite different labels and terminology being used to refer to a specific segment of text with Braun and Clarke (2006) using 'code' and Smith and Osborn (2008) referring to this as a 'theme'.

In addition, I had various discussions with Catherine Slack, who used this method in her doctoral research (Slack, 2015). I resonated with Hugo's observation that "a painstaking following of method has to be endured, a whole alchemy of change undergone" (Hugo, 2003, p. 42) as I undertook this arduous process.

5.8.1 Coding process

Step 1: Reading and re-reading the interview transcripts. Here the reader needs to read and reread the text (Braun & Clarke, 2006). I transcribed all of the interviews myself in order to become as closely acquainted with the material as possible. After each interview I recorded any noteworthy information, such as the length of the interview, the emotional state of the participant, questions that worked well or did not, or anything which had surprised me.

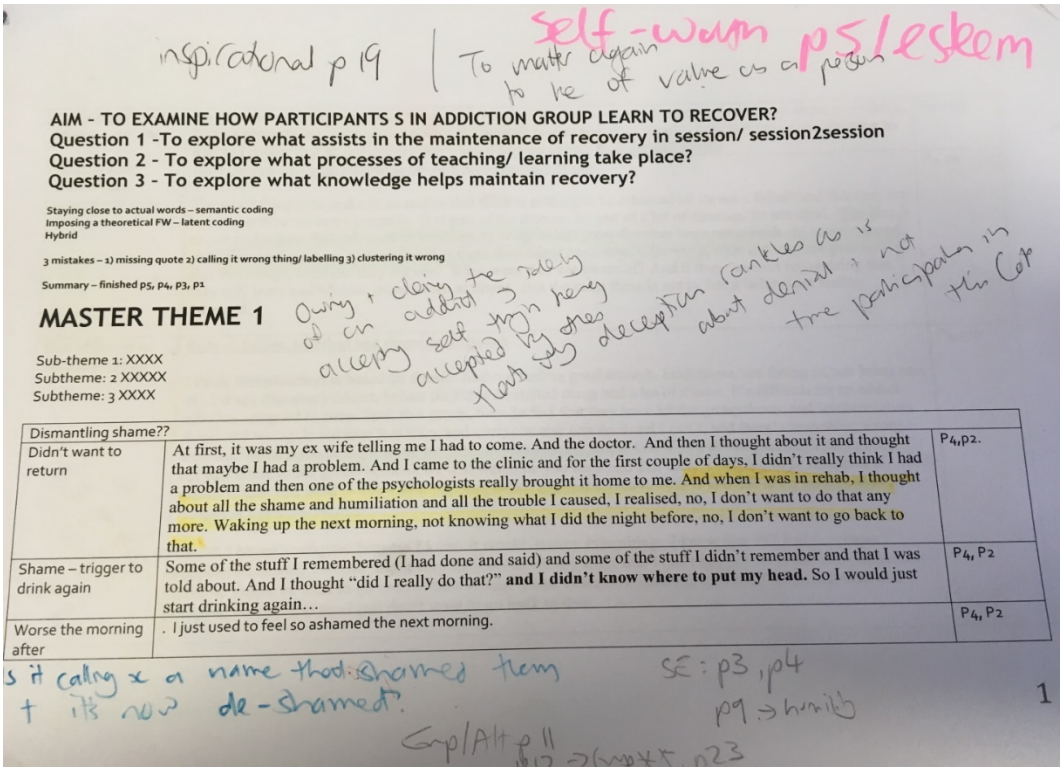
Step 2: Developing first-level codes. In this next step, the researcher codes the text by assigning labels to basic textual segments (Braun & Clarke, 2006) or attributing a word or phrase to textual segments (Green et al., 2007). I assigned codes to segments of the text which revealed a particular aspect of the phenomenon. The codes were words or phrases that would be easily understandable to both participants and academic readers, such as "dismantling shame", "rejecting self", "anger", "self-worth and self-esteem", "honesty" and "dynamics of the group facilitative of recovery". I coded demonstration of various emotions by the participants first, probably because emotions were easy to observe in the interviews and, because they were familiar to me, I felt confident about my ability to identify them (shame, anger, honesty). As I coded, the lived experience of addiction and its recovery via the group came into focus.

Step 3: Listing first-level codes. In this step, the researcher should list their emerging codes for each separate interview and examine them closely (Willig, 2008). Each interview was read through and the emerging codes were listed, and then developed as I went, to ensure multiple variations did not arise.

Step 4: Sorting first-level codes into code-clusters (sub-themes). In this step, Willig (2008) encouraged the researcher to cluster similar codes together. While participants demonstrated a range of different emotions, understandings and experiences, it was clear that difficult emotions and the aspects and dynamics of the group were overarching. The logical next step was to cluster codes that shared meanings or references together (Willig, 2008). Slack (2015) used the image of a magnet pulling similar codes together. These generated rich descriptions of emotions such as shame, anger, guilt, as well as other aspects of the addict's being that were transformed during group work, such as spirituality and physicality. In addition, it brought to light different aspects of functions and

mechanisms present in the group which comprised the pedagogy that contributed to the recovery of members of the group (e.g. developing self-esteem).

Step 5: Developing theme tables for individual interviews. In this step, Braun and Clarke (2006) suggested using visual aids as a means of capturing the patterns among various codes to order them into sub-themes. Braun and Clarke (2006) define a theme as "some level of patterned response or meaning within the data set that captures some significant aspect of the data in relation to the study question" (p. 99). I used the table structure developed by Braun and Clarke (2006) to aid the organisation of qualitative data to capture codes and code-clusters (themes) after each interview. The research questions were written across the top of the table to help me to bear them continually in mind. Given that I was novice researcher, I also included definitions of semantic and latent coding above the table to guide me.



inspirational p 19 | To matter again to be of value as a person self-worth p5/esteem

AIM - TO EXAMINE HOW PARTICIPANTS S IN ADDICTION GROUP LEARN TO RECOVER?
Question 1 -To explore what assists in the maintenance of recovery in session/ session2session
Question 2 - To explore what processes of teaching/ learning take place?
Question 3 - To explore what knowledge helps maintain recovery?

Staying close to actual words – semantic coding
Imposing a theoretical FW – latent coding
Hybrid

3 mistakes – 1) missing quote 2) calling it wrong thing/ labelling 3) clustering it wrong

Summary – finished p5, p4, p3, p1

MASTER THEME 1

Sub-theme 1: XXXX
Subtheme: 2 XXXXX
Subtheme: 3 XXXX

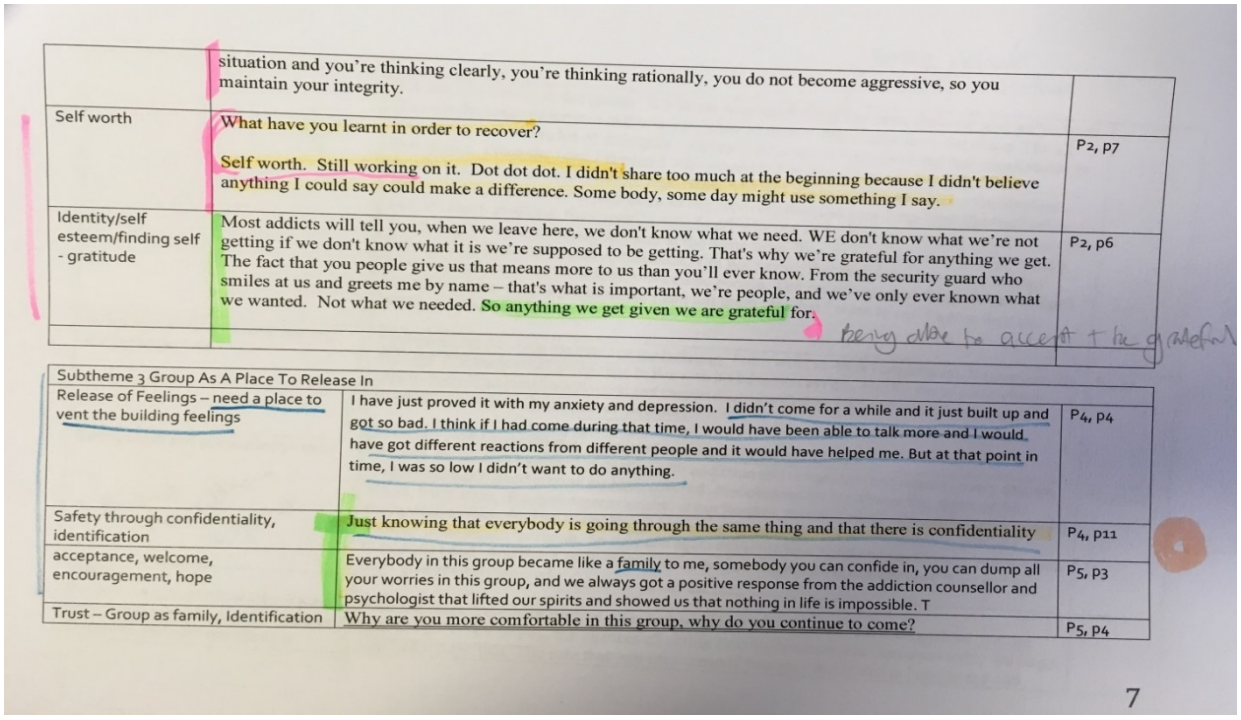
Dismantling shame??		
Didn't want to return	At first, it was my ex wife telling me I had to come. And the doctor. And then I thought about it and thought that maybe I had a problem. And I came to the clinic and for the first couple of days, I didn't really think I had a problem and then one of the psychologists really brought it home to me. And when I was in rehab, I thought about all the shame and humiliation and all the trouble I caused, I realised, no, I don't want to do that any more. Waking up the next morning, not knowing what I did the night before, no, I don't want to go back to that.	P4, P2.
Shame – trigger to drink again	Some of the stuff I remembered (I had done and said) and some of the stuff I didn't remember and that I was told about. And I thought "did I really do that?" **and I didn't know where to put my head.** So I would just start drinking again…	P4, P2
Worse the morning after	. I just used to feel so ashamed the next morning.	P4, P2

is it calling x a name that shamed them t it's now de-shamed. SE: p3, p4 p9 → humility Grp/Alt p 11 p13 → Grp x 5 p23

1

Figure 5.15 Example of table structure used to capture codes and themes

Step 6: Developing theme tables across interviews. Individual theme tables were studied to identify shared experiences, and from this a master theme table emerged. Common sub-themes were clustered together too into over-arching themes. The use of coloured pens to aid visual categorisation is very helpful while working across interviews to highlight themes (Slack, 2015, p. 100).



	situation and you're thinking clearly, you're thinking rationally, you do not become aggressive, so you maintain your integrity.	
Self worth	What have you learnt in order to recover? Self worth. Still working on it. Dot dot dot. I didn't share too much at the beginning because I didn't believe anything I could say could make a difference. Some body, some day might use something I say.	P2, p7
Identity/self esteem/finding self - gratitude	Most addicts will tell you, when we leave here, we don't know what we need. WE don't know what we're not getting if we don't know what it is we're supposed to be getting. That's why we're grateful for anything we get. The fact that you people give us that means more to us than you'll ever know. From the security guard who smiles at us and greets me by name – that's what is important, we're people, and we've only ever known what we wanted. Not what we needed. So anything we get given we are grateful for.	P2, p6

Subtheme 3 Group As A Place To Release In		
Release of Feelings – need a place to vent the building feelings	I have just proved it with my anxiety and depression. I didn't come for a while and it just built up and got so bad. I think if I had come during that time, I would have been able to talk more and I would have got different reactions from different people and it would have helped me. But at that point in time, I was so low I didn't want to do anything.	P4, p4
Safety through confidentiality, identification	Just knowing that everybody is going through the same thing and that there is confidentiality	P4, p11
acceptance, welcome, encouragement, hope	Everybody in this group became like a family to me, somebody you can confide in, you can dump all your worries in this group, and we always got a positive response from the addiction counsellor and psychologist that lifted our spirits and showed us that nothing in life is impossible. T	P5, p3
Trust – Group as family, Identification	Why are you more comfortable in this group, why do you continue to come?	P5, p4

7

Figure 5.16 Example of a master table coding and colour-coding themes that emerged across interviews

Step 7: Coding documents. I used this method to code transcripts of the audio recordings of three group sessions (not focus group sessions but meetings of the recovery group), as well as 100 of my post-recovery group facilitation notes. While this did add another dimension to the data, these documents did not add to the quality of data and in fact brought little new information to the study that had not already been captured on the table. I also conducted a content analysis of the 100 post-group facilitator notes using N-Vivo, which also did not yield much of value, possibly because it was too superficial. Many of the key issues in recovery emerged, which confirmed my identification of most of the

main topics dealt with in the group; it could thus possibly be considered to be a form of triangulation.

Table 5.4 Top 20 words in 100 session notes identified in N-Vivo

Word	Length	Count	Weighted percentage (%)
group	5	83	1,30
life	4	68	1,07
recovery	8	67	1,05
addiction	9	62	0,97
time	4	61	0,96
self	4	58	0,91
work	4	47	0,74
feel	4	46	0,72
people	6	45	0,71
now	3	44	0,69
family	6	42	0,66
relapse	7	42	0,66
back	4	41	0,64
sober	5	32	0,50
sobriety	8	32	0,50
support	7	32	0,50
triggers	8	32	0,50
want	4	32	0,50
way	3	31	0,49

Step 8: Continued coding of subsequent interviews. The focus group transcripts were then coded using the codes developed during the coding of the interviews as a guide, while also allowing new codes to emerge in order to arrive at a successfully integrated code list based on consistency across the process (Lavie-Ajayi & Willig, 2005; Slack, 2015).

Step 9: Continuing to structure codes into sub-themes and master themes. Tables for each interview continued to be developed, laying out coded extracts which were clustered into sub-themes. Master theme tables were developed that embraced sub-themes while containing all the codes, quotes and participant identifiers clustered into various sub-themes across all interviews. In this way coding and clustering occurred precisely, and I felt in control of the spread of data before me. This was what Braun and Clarke (2006, p. 89) called "analysing codes". Working with these master theme tables allowed detailed analysis of convergence and divergence within and across codes. In this analysis, each master theme composed of four or more sub-themes meaningfully within it.

Step 10: Naming the master themes. The master themes were considered and renamed where needed. Ultimately what emerged were names of the various aspects of the different parts of the self that transformed that ultimately resulted in spiritual, psychological and physical transformation. Other master themes were in response to the third question regarding knowledge and focused specifically on the group itself and the competency framework and regime of competence.

Step 11: Writing master themes into a narrative. Here the researcher is encouraged to write a detailed description of each emergent master theme (Braun & Clarke, 2006). As each master theme emerged, I wrote a detailed description of it, using both theory and literature to fully contextualise the theme before accounting for it as a nuanced aspect of the phenomenon of this study, interspersed with quotes from participants (Braun & Clarke, 2006; Slack, 2015). My intention was to reveal the narrative of each master theme and show how it fitted into the broader narrative of the phenomenon (Smith & Osborn, 2008).

As the master themes emerged, it emerged that the transformation of the person with addiction was a global transformation, affecting all aspects of her identity: physical, psychological and spiritual. Within the group itself, the aspects of membership and

accountability within the practice of addiction recovery were key to becoming competent in and maintaining recovery.

The writing and analysis became a recursive process, checking back to confirm accuracy of quotes and meaningful clustering as well as researching how they fitted into the master theme and contributed to it, as well as adding to the analysis and revelation of the phenomenon. All data extracts were checked to see if they were accurately collated in terms of sub-theme and master theme, and to ensure that the sub-themes and emerging master themes were well grounded in the original transcripts (Braun & Clarke, 2006; Willig, 2008).

Step 12: Considering 'saturation'. Saturation can be defined as the point where continued data collection ceases to yield substantial new information (Tong et al., 2007) and "rather reiterates what has already emerged" (Wagstaff et al., 2014, p. 726). In this study it was possible to develop new first-level codes for each interview; however, beyond that there was a repetition of sub-themes and emergent codes which were not really new and could be subsumed under previously existing clusters or themes. Saturation was also indicated by the fact that once everyone who was prepared to participate in the study had been interviewed, there were no new sources of interview data. In addition, that only two people were willing to participate in the final focus group was a probable indication that there would be no more forthcoming participants if additional focus groups were held; data that could be obtained from this source was also exhausted.

Step 13: Checking if themes were internally consistent and distinct. In this step, checking as to whether the data within a theme has meaningful coherence is encouraged (Patton, 1990, in Braun & Clarke, 2006), as well as whether aspects of a theme cohere around a core concept (Braun & Clarke, 2006) and whether the particular theme has internal consistency. Internal consistency refers to data cohering meaningfully around a theme (Fossey et al., 2002) and when aspects of a theme cohere around a central concept (Braun & Clarke, 2006). I checked my themes against these criteria and also ensured that there were distinctions, without excessive overlap, between themes (Braun & Clarke, 2006). Because of the interrelatedness of themes, it is possible for the same sub-theme to emerge under more than one master theme (Braun & Clarke, 2006). I found that I had to

address this problem. One of the places where this had occurred was in the case of quotes, which were used to illustrate more than one theme.

Step 14: Interpreting master themes. In the final step of coding and analysis, the researcher takes a meta-position and interprets the themes that have emerged back to the participants for their own edification and well-being. The researcher can interpret themes using theory and literature to contextualise them for the participants (Flowers et al., 2000; Larkin et al., 2006; Willig, 2008).

Once this research was completed, I presented the key findings of this project to the participants. This was intended to 'close the circle' and my hope was that this would be a validating and empowering experience for them. The point of research is, arguably, to bring it back to the world, to better the world if even just a little.

5.8.2 Role of supervision

Academic supervision can play a key role during data analysis, especially in relation to the interpretation of emerging themes (Drake et al., 2006; Larkin & Griffiths, 2009; Slack, 2015).

In my experience, the fact that my supervisor was genuinely interested in my research was very motivating. His willingness to push the boundaries of the work — encouraging me to believe that I was capable of even better work even when I felt I had already given my best — contributed positively to the work and to my own development as a researcher. His meta-position with regard to me and the data enabled him to see things that were not in my immediate view, often regarding connections to other themes and my phenomenon (he thus provided 'super' vision!). These included issues around my positionality as an 'insider researcher' and major themes around spirituality and religion and the physicality of addiction recovery that had somehow slipped me by. My lens as a psychologist for the group was perhaps too dominant at times and, as such, 'non-psychological' issues were perhaps less obvious to me. For this reason, having a supervisor with a different lens and focus than my own significantly enriched the research. Throughout the intensive process of coding and analysis, he worked with me to develop, challenge and deepen the themes that emerged, helping me to relate these to theory and the literature and theory, to work

accurately with each participant's statements, and to link themes accurately to master themes and ensure their relevance to the phenomenon and the study.

5.9 ETHICS AND POSITIONALITY

My positionality as both group psychologist and researcher had a significant bearing on the ethical aspects of this study. It could be argued that the deep knowledge of processes and participants which this allowed produced data of a higher qualitative standard than would otherwise have been possible; however, certain safeguards and cautions needed to be put in place in order to protect the ethical integrity of the study.

I successfully defended the proposal for this study in September 2014 and applied for ethical clearance from the Humanities and Social Sciences Research Ethics Committee at the University of KwaZulu-Natal. Because the study involved a vulnerable group, my application was assessed as a 'code red', requiring a meeting of the full committee to obtain approval, which happened in October 2014. After I had addressed the committee's concerns, I was awarded full approval and ethical clearance was granted in February 2015.

The committee's main concern was around the perceived conflation of the roles of psychologist and researcher. To overcome this, it was necessary to ensure that all participants in the study were capable of giving informed consent, and of clearly distinguishing between our relationships as therapist and support group participants, on the one hand, and as researcher and research participants, on the other. In other words, they needed to be clear that they were not participating in any additional treatment by participating in focus groups or interviews conducted by myself as a researcher, rather than as their group psychologist. I needed to be mindful of the vulnerability of this group of research participants and the effect that communication around study participation could have on them.

I read the work of Appelbaum and Wassenaar (Appelbaum et al., 2012) and subsequent research (Appelbaum et al., 2009; Appelbaum et al., 1982; Kimmelman, 2007) that had emerged on the concept of 'therapeutic misconception'. This originally related to the conflation of the medical practitioner as health care provider and (clinical trial) researcher

due to inadequate informed consent procedures that did not adequately distinguish between the two different roles. The result was that participants believed that because their own doctor was involved as a researcher in the clinical trial, s/he would give them the best possible treatment — which has been referred to as 'therapeutic optimism' (Jansen, 2011). The wider application of this concept refers to a patient/research participant being confused about whether s/he is receiving experimental treatment or ordinary care. This notion of therapeutic misconception has spread across disciplines during the increase in clinical trials over the past 20 years (Appelbaum et al., 2009).

Strategies which have been proposed to minimise therapeutic misconception include giving a clear description of the research procedures and goals to the participant and having a comprehensive discussion with the prospective participant about the voluntary and optional nature of participation and available alternatives — highlighting the difference between the research, per se, and any therapeutic interventions being offered (Christopher et al., 2017). Historically, health care practitioners have been permitted to conduct research despite this role conflation as long as adequate measures have been put in place to facilitate full understanding of the research process by the participant during the consent process.

While this was a concern of the UKZN Humanities and Social Sciences Research Ethics Committee, I did not agree that it was a concern for this study as I was not researching an experimental health service. Instead, I was researching how addicts learn to recover from their addiction and my research sample was being drawn from an addiction group that I facilitated. In other words, the participants were all participating in the treatment, so to speak, which was not being trialled.

The issue was simpler, in fact — it was a dual-role conflict rather than a therapeutic misconception. However, it was still important to ensure that the participants in the study were made fully aware, through the consent process, that their involvement was as research participants and not as therapy clients, and that I did not instil false hope that participating in the study would directly benefit their recoveries or that they would get any 'special treatment' from me if they participated.

As the researcher, it was important that I developed a strategy for working with the dual-role conflict and possible perceived bias. From the outset, it needed to be made clear that

I, as the researcher, had no invested agenda in the outcome of this research — there was nothing to be 'experimented on' or trialled — and my intention was solely to explore how addicts had learned to recover in an addiction recovery group that was facilitated by myself.

I planned to use this potential positional bias in a critically reflexive way. One of my strategies was to keep a reflective journal during the data collection process to capture any aspects of my experience. One observation I noted was that it could have made data collection much easier had I employed an independent interviewer: ironically, not because the participants would have said more, but because they might have said less. Had I not also been their group therapist, I may have found it easier to ask them to get to the point. I did not want to risk the therapeutic relationship (even though I was not in the role of their therapist at the time), so when they went off topic, I brought them back more gently than I would have had I been solely a research interviewer.

Conversely, I attribute the fact that all of the participants shared deeply and personally to our history of at least a year of working together therapeutically in the group on a weekly basis. I believe that the richness of the data that was obtained in this study would not have been possible had there not been a strong bond of trust built up from working together in the recovery group. At times, particularly during the follow-up questioning, I slipped into therapeutic probing (reflecting feelings and being compassionate and sympathetic) which probably did elicit deeper answers. While I tried to maintain the role of research interviewer, I do think that the roles blurred at times. Having said this, there is no reason why a research interviewer should not be compassionate and sympathetic. Perhaps I was aware that I was doing this to facilitate the expression of research data for my own research aims, rather than solely for their benefit, but this was nonetheless appropriate in the research context.

The notion of 'insider research' can also be applied to my positionality. Cautions that have been raised regarding some of the challenges of this position include: leaving space for discussion of the process of research and data analysis (Kimmelman, 2007); instilling the false hope of cure (Ellis-Caird, 2017); emotional investment on the part of the researcher, and managing appropriately boundaried relationships and issues relating to self-disclosure (Moore, 2012); being aware of power differences and holding authority over participants (Ross, 2017); the awareness of ambiguity and of an 'in-between'

existence while balancing the demands of both roles (Hanson, 2013); and socio-cultural sensitivity (Kim & Jeffreys, 2013). These were all relevant to this study and were addressed during the appropriate stages of the research in order to make the work richer and more robust.

When attempting to view the addicts from the 'outside', I became distanced and detached and aware of issues such as stigma. When I saw the participants as members of the recovery group whom I worked with and knew, however, I held no such judgements. Instead, I felt a deep warmth and respect for them in their recovery journeys. Having worked with them weekly for over a year each, and some for even longer, I had a sense of who each of them was and their struggles and successes. They, too, had a strong sense of who I was as a person, despite extremely little self-disclosure on my part in order to fulfil my role as a boundaried, professional psychologist. I believe that this contributed positively to their willingness to participate in this study as well as the depth, quality and quantity of data generated. In fact, I suggest that it was due to my positionality in the addiction recovery group that new contributions to knowledge could be made with a group of people who may well have felt ashamed and awkward speaking about vulnerable aspects of their recoveries with a stranger. The concept of empathy is important — and having empathy for the participants in their recovery work in all probability translated into having empathy for them in the data collection process too.

I do think, in retrospect, that it may have been useful to have an independent interviewer to interview participants about my role in the group as an additional data source. Participants may well have been more critical if interviewed by someone else.

Nonetheless, I believe that the benefits of doing the interviews and transcriptions myself outweighed the drawbacks. It enabled me to be as close to the data as possible. Listening to phrases repeatedly as I transcribed them instilled a confidence in me over time that I was hearing and understanding what was intended.

As mentioned earlier, I facilitated the group until July 2016, but continued the data collection until November 2017. This meant that there was over a year in which I did not work therapeutically with the participants. As a result, I did not feel as connected to the participants when I interviewed them over a year later. Somehow this made it easier to ask difficult questions — such as how they experienced being let down by other group

members who break their word (accountability). It felt as if there was more space between myself as the researcher and them as the participants, which allowed me to explore issues more rigorously. My sense was that the honesty and depth of their responses was based on the trust they had in me.

I think that being their group therapist meant I felt responsible for their emotional well-being and may have avoided exploring difficult issues — such as membership, accountability, deception, betrayal or dishonesty — without being aware of it at the time. As their therapist, I had a responsibility to the other members of the group, and it would have been unethical to ask them to talk about others who were not present in a particular way. This would have compromised the integrity of the group too, had I done this. I realise, in retrospect, that the well-being of the members of the recovery group was paramount to me, even at the expense of the research. In the final interview, however, data emerged (regarding the regime of competence) that might well not have, had the participants and I not had both a trusting and confidential relationship as a result of our history together, as well as the distance from the group created by the fact that I no longer worked therapeutically with the group.

For those considering doing research that involves dual roles, as in this study, I strongly advise giving careful thought to whether one can truly 'serve two masters' or whether one will be served slightly more at the expense of the other — and what impact this would have on the research (or on the practice). This forms part of my contribution to methodological concerns regarding dual roles and insider research.

5.10 ENSURING THE QUALITY OF THE STUDY

In order for research to demonstrate an adequate standard, it must be ensured that the methods used generate data "that can provide for and substantiate meaningful and significant claims" (Tracy, 2010, p. 841).

Many different criteria have been put forward to assess the rigour, or quality, of research. While validity and reliability are the criteria generally used to evaluate positivist research, they are deemed less appropriate for qualitative research (Cohen et al., 2011; Denzin & Lincoln, 2011). Researchers operating within constructivist-interpretive paradigm

advocate using the criteria of trustworthiness, credibility, transferability and confirmability (Morrow, 2005).

This section explores the measures of quality appropriate for a case study of an addiction aftercare group.

5.10.1 Trustworthiness

Guba (1981) argues for trustworthiness to be used as the overarching criterion for judging the worth of constructivist-interpretive research. He holds that the term encompasses four important concerns: the truth value, applicability, consistency and neutrality of the research. While these aspects of trustworthiness are typical of all research, they are 'translated' somewhat differently according to the research paradigm. Thus, where the 'scientific' (positivist) paradigm would utilise internal validity, generalisability, reliability and objectivity, in the 'naturalistic' (interpretive) paradigm the appropriate parallel constructs are *credibility*, *transferability*, *dependability* and *confirmability*. These were addressed in this study.

Being able to provide affirmative responses to the following questions posed by Bassey (1999, p. 76) was taken as a measure of the trustworthiness of this case study:

- "Has there been a prolonged engagement with data sources?"
  Yes: from March 2015 until the thesis was handed in in November 2019.
- "Has there been persistent observation of emerging issues?"
  Yes: through this time as well as through the recursive process of research.
- "Have raw data been adequately checked with their sources?"
  Yes: participants were given typed up transcripts of their interviews to read, and focus groups began with a summary of findings from the previous focus group for accuracy and comment.
- "Has the … working, emerging story been systematically tested against the analytical statements?"
  Yes: there is a homologous correspondence and the interplay between the deductive and inductive aspects were challenged numerous times by myself and my supervisor.

- "Has a critical friend thoroughly tried to challenge the findings?"
  Yes: my supervisor, during intense supervision sessions where there was an interrogation of concepts against the data, a seeking of elaboration to examine depth of understanding, that there may be other possibilities of interpretation or omissions and mistakes were considered, and the data and conceptualisation was repeatedly challenged by him. During this process the notion of the spiritual/religious aspect of recovery emerged, as well as the notion that the addict becomes a good person not only for its own sake but in order to see relapse coming through changes in thought, word or deed in the integrity of the person. The importance of 'insider research' also emerged in terms of empathy for my study participants. The challenging interrogation from my supervisor assisted in the removal of many of my blind spots and opened up the scope of the work greatly. I also discussed some of my findings with members of a UKZN Adult Education PhD cohort on various occasions.
- "Is the account of the research sufficiently detailed to give the reader confidence in the findings?"
  I believe so. I have explained what I did as fully as possible, while also following conventions for writing up this chapter and accounting fully for every aspect I could find.

I used many of the strategies suggested by Bassey (1999). This was also encouraged by Fossey as a means of promoting trustworthiness (Fossey et al., 2002). It has been advocated that credibility-enhancing strategies be included in qualitative research to strengthen the overall quality and credibility of the research (Guba, 1981).

5.10.2 Credibility

Credibility, or 'truth value', centres on the researcher's ability to take full account of the "bewildering array of interlocking factor patterns that confront them and to produce findings that are plausible" (Guba, 1981, p. 84).

Credibility, as well as commitment, can be promoted by prolonged engagement with the study participants in context (Guba, 1981). This transpired in this study by engaging with them in a variety of ways — eight individual interviews and five focus groups over

seventeen months, and while working with them initially once and then twice a week for a five-year period during much of that time. As such, rapport and trust were built with the study's participants that enabled a high quality of data to be collected. Honesty being one of the key issues to emerge from the research led me to consider that the potential for "social desirability" in interview responses (Baxter & Jack, 2008, p. 556) had been reduced and what was said was true. Because so much of what was said in the interviews had also been said in the group itself, I knew it to be true. In addition, many participants said similar things, providing thematic credibility. Furthermore, I typed each transcript out myself to bring myself as close to the material as possible.

Another way of enhancing credibility was member checking, whereby participants were asked to verify, discuss, clarify and/or contribute new insights to the researcher's interpretations of the data (Baxter & Jack, 2008). This happened individually when participants were given transcripts of their interviews to read as well as during focus groups, when findings from the previous group were discussed and commented on for this reason. Soliciting feedback from participants is another strategy for enhancing the credibility of the research and, at the very least, it can be a useful strategy if major factual errors exist (Thomas, 2017) and if the participants' views have been misrepresented in any way (Giacomini & Cook, 2000). It has been argued that expecting higher order conceptualisation or theoretical interpretation when participants are not well placed to give that needs to be born in mind (Yardley, 2008).

Triangulation is the use of a variety of perspectives, methods, or sources of data and is considered to be a further way to ensure confidence in one's research outcomes (Guba, 1981; Koch & Harrington, 1998). When the same phenomenon is observed from more than one data source, a richer explanation is created, the researcher gains confidence and credibility is strengthened (Baxter & Jack, 2008). The point of triangulation is not to strive for agreement but to enrich the description of the phenomenon (Cohen et al., 2011). This was strived for in data collection and analysis, as well as the literature and theoretical aspects of this study.

Making use of more than one researcher has been suggested as a way of strengthening the credibility of a study — not with the aim of consensus but to enrich the analysis through the use of different perspectives (Malterud, 2001, p. 484). The data was coded and discussed with one other researcher (Catherine Slack, PhD), and my supervisor, Prof.

Wayne Hugo, checked the coding and analysis, pointing out aspects that I had not seen (for example, why honesty is so important in recovery, and the physical nature of recovery). This enabled a more complex account of the phenomenon.

Credibility is also enhanced by the provision of verbatim extracts, which allows the reader access to the interpretations made and highlights the "centrality of quotes as a form of evaluation in qualitative research" (Malterud, 2001, p. 27). The selected extracts provided in this study often represent the most articulate expression of a sub-theme. Because I highly value giving voice to the participants, I may have been overzealous in this aspect; however, I wanted to bring the reader as close to the phenomenon as possible.

Another way of strengthening credibility is to look for dis-confirmatory evidence of sub-themes or major themes, or to show how patterns are contradicted (Brocki & Wearden, 2006). It makes sense that all those within a sample would not have the same experience, and so accounting for exceptions would be expected, or that different participants may exhibit aspects of the theme in different ways (Braun & Clarke, 2006). Under most of the major themes, the codes were specific enough to capture the nuances of different participants' experiences. However, in the section on spirituality, what emerged was that those who were spiritual before they went into recovery remained spiritual and perhaps grew even more so, and those who had not been spiritual remained as they were. The section was too important to many to omit, even though it did not account for everyone.

5.10.3 Transferability

Transferability is deemed the alternative criterion to (quantitatively orientated) generalisability. Because the phenomena of qualitative study are considered to be context-bound, the intention of research is not to produce 'truth' statements that can be generalised, which is the aim of positivistic and quantitative research, but to develop descriptive, context-relevant statements (Guba, 1981)

A strategy to achieve transferability is the crafting of detailed descriptions of the data and of the context, so that the reader is in a position to make his or her own comparisons to other contexts. The idea of "reader-determined transferability" (Guba, 1981; Rule & John, 2011, p. 105) implies that by providing sufficiently rich, detailed descriptions of the case,

the researcher is relieved of the 'burden' of transferability claims, because the reader is then free and able to decide the level of transferability of the research findings. Rule and John (2011, p. 108) have also noted that thick descriptions contribute to credibility by portraying the "fullness and essence of the case reality". An aim of this study was to provide rich, contextualised descriptions related to the group context; this is why the thesis has been structured with so much space devoted to thick description and integration of the emergent findings with literature.

The use of theoretical or purposive sampling — which was utilised in participant selection — can also promote transferability (Rule & John, 2011). Such sampling "is not intended to be representative or typical but … is intended to maximise the range of information uncovered. The nature of the sampling process is governed by emergent insights about what is important and relevant" (Guba, 1981, p. 86). Indeed, with nineteen participants and very few others available, I am satisfied that the range of information that was uncovered was maximised.

The power of a study can be assessed by the connections between the findings of the study and claims in the existing literature, i.e. theoretical generalisability (Guba, 1981). This would then have provided data that would extend conceptual understanding and make a contribution intellectually (Smith & Osborn, 2008). So, while as a case study this research is constrained by the limitations discussed, it is important to consider the "extent to which interpretive account can be applied beyond the study context" (Tracy, 2010, p. 83) and into other contexts usefully. To this end, participants should be described in order for the readers to assess which findings and situations may be relevant (Tracy, 2010). Researchers are also encouraged to set out the methods, findings and interpretations extensively so that the reader is able to determine their applicability to other settings (Elliot et al., 1999).

I have attempted to do this, with the aspiration that this study will be useful to other and similar contexts.

5.10.4 Dependability

Dependability concerns the stability of the data, and addresses "apparent instabilities arising either because different realities are being tapped or because of instrumental shifts stemming from developing insights on the part of the investigator-as-instrument" (Guba, 1981, p. 86).

The creation of an audit trail in the form of case documentation and a running account of the process has been posited as a good means of enhancing dependability (Baxter & Jack, 2008; Guba, 1981). Process notes were made after every interview and focus group that I conducted, and a running account of the process was kept when any thought about my research occurred to me. These informal notes contained my own reflections and interpretations and served to increase my awareness of various aspects of the research. While this would not be considered a formal data source, I did discuss these notes with my supervisor and the insights from both the notes and discussions influenced aspects of the research.

An audit trail indicates how patterns were identified and how data was verified in its analysis and interpretation (Baxter & Jack, 2008). Cohen and Crabtree (2008) suggest that researchers explain how they analysed data with concrete examples in order to reassure the reader that the researcher is actually analysing the data before them and not projecting their own ideas onto the participants' words. This helps potential auditors establish that the account produced was done systematically and not that it was the only credible account that could be produced (Reynolds & Prior, 2003). The creation of an audit trail adds to confirmability in that it allows findings to be traced back to data sources and provides a record of the experiences of the participants free from any researcher bias (Shinebourne & Smith, 2009).

The previous section described the coding of the data and its clustering into code-clusters (sub-themes) and organisation into master themes.

5.10.5 Confirmability

Confirmability focuses on the objectivity of the data and relates to the minimisation of investigator bias. (Guba, 1981).

A further practice for increasing confirmability is researcher reflexivity, which concerns the researcher being transparent about assumptions or biases that could affect questions or interpretations, as suggested by Goebel (2017). I have discussed relevant aspects of my background, experience and interests with regard to my positionality and have endeavoured to maintain an awareness of how these might have affected my findings, as suggested by Guba (1981). Creswell (2013) encourages researchers to state their theoretical orientations. Slack (2015) suggests noting influences on how the problem was formulated. For Elliot et al. (1999), researchers should try to expose preconceptions, initial beliefs or anticipations about the topic. They should give their reasons and motivations for wanting to do the present study based on personal involvement or practical experience with the phenomenon (Elliot et al., 1999; Malterud, 1993), and should disclose their training, previous personal and professional experiences (Malterud, 1993, 2001), and occupation and relationships with participant. These have been made explicit so that the reader can assess the impact on the interpretations.

Using the case study methodology, the bricolage approach to deep interdisciplinary research, the weaving of theory and praxis from more than one discipline, and thematic and IPA analysis, I have attempted a unique account of the phenomenon that is the focus of this study.

5.11 LIMITATIONS OF THE STUDY

Interpretation of the findings of this study is subject to some limitations arising from the nature of the case and the research design. The study drew on a small sample of participants who regularly attended a particular addiction aftercare group in a single setting, for a specific length of time, with a single researcher who was also the co-facilitator of the group. Hence, it is possible that different results would emerge from other groups of recovering addicts, with different ages, locations, substances of choice, pedagogic approaches, group structures, facilitators, or other contextual variations. The study group may have benefited from more diversity in its participants in terms of culture and gender, and urban and rural participants. Studying a state-funded aftercare group as opposed to a private one may also have been useful.

Also, had the study involved more than one recovery group — for example, had I included a twelve-step group that I did not facilitate — this would have enriched the study on issues such as membership and accountability, the experience and importance of empathy and mentalisation, as well as pedagogy.

However, case study research is not ultimately intended for generalisation, but instead seeks to enable a deep, holistic and contextualised understanding of a specific phenomenon. The findings reflected in this research are thus specific to this particular case, as they are based on the participants' personal meaning-making and are limited to the immediate context (Green et al., 2007). Still, the intention of this study is that extrapolations will be made; these need to be done with consideration for these limitations. It hoped that the 'One' is found in the 'one' (Rule & John, 2015).

The focus solely on group participants introduced possible further limitations. It was for this reason that I interviewed all three addiction counsellors who co-facilitated the group, as they had experienced their own recoveries through a group process. I could have widened the selection of participants to include other stakeholder groups, such as inpatients, clinic staff, or family members of addicts who had completed a year of recovery in the group; however, I wanted to focus only on the addicts' experience of how they learned to recover via a group. Content limitations may exist around the types of interventions used in rehabilitation treatment specifically in South Africa, and the reasons addicts ultimately enter recovery. However, I chose to restrict the scope of the study to the phenomenon of the mechanisms of the addiction recovery group.

Another possible limitation is that bias may have been introduced into the study as a result of my dual therapist/researcher relationship with the participants. In the interview situation, in particular, this may have biased participants' responses towards giving answers they believed would please me. Even though I did not hold a formal evaluative position in their lives, I did hold power in the group, which may have had an impact on their responses.

The participants in the study had diverse characteristics but the majority were older, white males. My own personal characteristics as an older, white, South African female, and a first-language English speaker, might have affected how the participants engaged with me, especially given the patriarchal nature of South African society and the domination

of male privilege in many groupings, as well as the apartheid history of the country. However, respect was shown to me for my position in the group and as a researcher. I wonder if, had I been a young Zulu female, this would have been the case. I suspect it would have, as the group viewed mutual respect as paramount. My hope is that I proved myself to be someone worthy of the participants' trust; a number of comments by participants confirmed this. I like to think too that it translated into the participants' co-operation, mutual respect and good will.

My subjectivity as a professional psychologist and (experienced) group facilitator, as well as my own personal investment in this study as a PhD candidate, was another potential source of bias. For this reason, my own positionality is an important part of this work and contributes to the understanding of methodology in a dual-role research situation.

5.12 RECOMMENDATIONS FOR FUTURE RESEARCH

Further research could certainly investigate relationships between the various aspects and competencies — perhaps over time, as there is a paucity of research on longer term recovery, or in groups comprised of different participant demographics, certainly within South Africa. This could strengthen the findings of this singular case study.

From a practitioner point of view, groups could be introduced in disadvantaged communities with an intentional focus on these aspects of the group and recovery. Research could be conducted on these groups, as they are a cost-effective and constructive method of intervention.

The exploratory nature of the qualitative research approach invited the participants to share their stories freely, with no hypotheses or predefined goals and assumptions. This generated new data on the nature of addiction recovery and the mechanisms of the group that facilitates this learning. Future research, both quantitative and qualitative, could examine these mechanisms of learning in a group further, and compare them to other groups and examine their effect on the individual transformation of addiction.

5.13 CONCLUSION

The chapter has presented the methodology used to study the phenomenon of how addicts learn to recover via a group process. To this end, the following aspects were covered: ontology, epistemology, interpretative paradigm, qualitative methodology, the researcher's positionality, case study and its theory and appropriateness, bricolage, context, participant selection, motivation for the study, ethical aspects (including the therapeutic misconception and insider research), data collection and analysis, coding, limitations and the various ways that quality was ensured in the study. This study makes a methodological contribution in the area of a South African case study of addiction recovery and the area of insider research and positionality.

This concludes the first part of this study. It has contextualised the phenomenon within the landscape of addiction and recovery globally and within South Africa and has introduced and presented literature on mutual-aid and therapeutic group work as effective models in recovery. Addiction and recovery have been grounded in theories of social learning (particularly communities of practice) and psychoanalytic understandings of addiction (especially Khantzian's self-medication hypothesis and attachment theory) and psychodynamic group work. This part of the study has concluded with a presentation of the research design and methodology in this chapter. This provides background knowledge to the findings discussed in the second part of this study.

PART TWO: FINDINGS

PART TWO: FINDINGS: MECHANISMS OF TRANSFORMATION

The second part of this study presents the findings by answering the three research questions.

Chapters 6 to 12 detail the transformation of the self of the addict, answering the first two research questions, namely:

1. What in, or about, the group assists regular participants to sustain their recovery?
2. What pedagogic mechanisms are used in the group?

The answers to these questions form a device entitled the **Mechanisms of Transformation**.

A significant finding that emerged from this study is that the transformation of the addict achieved via group participation involves various major aspects of the person of the addict: spiritual, psychological and physical. The transformation of these aspects results in identity change, which enables them to sustain recovery. In this section, these three aspects are each discussed in their own chapter, with findings situated in the context of relevant literature, following the bricolage method. Chapter 6 explores the role of religion and spirituality in addiction and recovery. Five key psychological aspects of addiction and recovery which were addressed by mechanisms in the recovery group are then discussed: shame (Chapter 7); anger (Chapter 8); honesty (Chapter 9); empathy and mentalisation (Chapter 10); and self-esteem (Chapter 11). Chapter 12 explores the physical transformation that occurs in the journey from addiction to recovery.

Chapter 13, "From Competency Framework to Regime of Competence", presents findings related to the third research question, namely:

3. What knowledge helps participants sustain their recovery and is useful to them in the maintenance of recovery?

This chapter, which changes in tone from previous chapters in this section, pulls together the findings from the five focus groups, individual interviews and the application of the technical terms used in communities of practice theory to elucidate the knowledge needed to sustain recovery in a support group context and set up the last chapter of this thesis and its contribution to knowledge on recovery. The thesis concludes with Chapter 14.

CHAPTER 6
THE ROLE OF RELIGION AND SPIRITUALITY IN ADDICTION AND RECOVERY

Spiritus contra spiritus: "Spirits (alcohol) and spirituality seem to be mutually exclusive. They drive each other out."
— Carl Gustav Jung in a letter to Bill Wilson of Alcoholics Anonymous (Jung, 1963)

6.1 INTRODUCTION

A key theme to emerge from this study was that of spirituality and religion. The complex links between religion and spirituality and addiction and recovery are well supported. The study found that those who were spiritual or religious to begin with remained so, and those who were not remained as they were: the journey of recovery strengthened the belief of those who had it to begin with.

6.2 UNDERSTANDING RELIGION AND SPIRITUALITY

In its broadest use, the term "religion" might be used to include both spirituality (concern with the ultimate questions of life and its meaning and transcendence) and religiousness (specific doctrinal, behavioural, social and denominational characteristics) (Borras, 2010; Mohr et al., 2006). However, there are important distinctions that can be made between religion and spirituality. Tanyi (2002) clarified the relationship and differences between religion and spirituality as follows:

> Spirituality and religion are often used interchangeably, but the two concepts are different. Spirituality involves humans' search for meaning in life, while religion involves an organized entity with rituals and practices about a higher power or God. Spirituality may be related to religion for certain individuals, but for others, such as an atheist, it may not be. (Tanyi, 2002, p. 500)

6.2.1 Religion

The term "religion" is derived from the Latin word *religare*, which means "scrupulous or exacting in the performance of rituals" (Miller, 1998, p. 981). Miller (1998) argued that religion can be defined by three main characteristics: specific belief, specific religious practice and specific religious sentiments where there is agreement among followers. Miller and Bogenschutz (2007) considered religion to be a social phenomenon defined by specific boundaries such as belief, practice and membership. One function of religion is to facilitate the development of its followers' spirituality (Heinz et al., 2010) into a more highly specialised concept characterised by a personal relationship with a higher transcendent power beyond the self (Cook, 2004). The aspect of religion that does this is the aspect in which it has been defined as an organised social phenomenon (Miller, 1998). This social aspect dovetails with a similar aspect in social learning.

6.2.2 Spirituality

Astin (2004) proposed that spirituality is about the core of our interior world: human consciousness, meaning making, the affective dimension of our being, our deepest sense of values, and a sense of mystery that defies definition. For Galanter (2006), spirituality refers to a specific, highly personal experience of what an individual considers sacred and is not mediated by a specific belief system or through roles such as priest or rabbi (which would constitute religion); it is therefore possible to develop deep spirituality without practising a religion. Swinton (2001) suggested that spirituality refers to a dimension of experience and belief common to all humanity which we share with others, and aspects of experience and belief which are unique to the individual. It implies the oneness and interconnectedness of each other and all things. In South Africa, the spiritual aspect of *ubuntu* would be located here.

Cook (2004), in an analysis of 265 published books and papers on addiction and spirituality, found that the use of the term "spirituality" lacked conceptual clarity. Cook (2004) identified thirteen characteristics of spirituality: relatedness, transcendence, humanity, meaning and purpose in life, authenticity and truth, values, non-materiality, wholeness, self-knowledge, creativity and development of consciousness and awareness; and proposed that "[s]pirituality is a distinctive, potentially creative and universal

dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions" (Cook, 2004, pp. 548–549).

6.2.3 Measuring spirituality

Numerous interpretations and definitions have arisen regarding the notion of spirituality and how this has been operationalised in research (Walker et al., 2013). Although various instruments exist for measuring spirituality, studies have been criticised for using simplistic, often single-item measures (Geppert et al., 2007) which fail to recognise that spirituality is multidimensional, complex, dynamic and bounded in culture, time and space, including behaviour, belief and lifestyle (Miller, 1998). As most studies have been conducted in the First World, particularly in Europe and North America, questions surrounding the cross-cultural applicability of instruments remain (Wulff, 2014). Galanter (2006) devised an assessment scale measuring many variables considered key to spirituality, including spending time privately in thought and prayer, enjoyment of spiritual readings and activities, the extent to which spirituality assists in balancing and steadying the person's life, and the extent to which the person bases their life on a spiritual, moral approach; this assessment tool does not seem to have been used after 2007. From the literature it appears as if the measurement of spirituality has not been followed up much in the past decade. Spirituality is probably best conceived of in an interpretive framework where the experience, meaning and nuance can be explored and expressed.

6.3 RELIGION AND SPIRITUALITY IN THE CONTEXT OF ADDICTION AND RECOVERY

The Latin word *spiritus* has several meanings: it refers to the highest religious experience possible and at the same time to alcohol — for many, a deadly poison (Allamani et al., 2013); it is the root of the word "spiritual" and also means "breath". To breathe is one of the fundamentals of life. Breath work is a spiritual practice in various traditions ranging from ancient yoga to modern New Age practices and approaches, such as Mindfulness-

Based Stress Reduction. Many practices use breathing to connect to something beyond the individual. In southern Africa, the Nguni langua ges have the same word for breath, spirit and wind: *umoya*. This suggests a commonality of experience and meaning among human beings, regardless of culture, geography, history and context.

A body of research exists linking addiction, recovery, religion and spirituality (DiClemente, 2013; Emrick & Tonigan, 2004; McCrady & Tonigan, 2009; McKellar et al., 2003; Moos, 2008; Moos & Moos, 2006; Pargament & Park, 1997). Research has shown that the more religious a person is, the less likely they are to become an addict (Booth & Martin, 1998; Kendler et al., 2003; Koenig et al., 2001; Midanik & Clark, 1995) and, conversely, substance abuse issues are associated with low religious practice and belief. Religion can play a preventative role in addiction by providing a code of conduct for its followers — which may forbid the use of intoxicating substances — and a supportive community with structured codes of behaviour and coping strategies (Koenig et al., 2001). Membership in a religious community thus can include the characteristics of practice and identity common to communities of practice.

While many religions take a position regarding intoxicating substances — with Islam forbidding its use completely, while wine is allowed only for controlled ritual uses in some Jewish and Christian traditions — some religions, such as Rastafarianism, encourage drug use. Native American cultures advocate the ritual use of chewing tobacco and peyote. South American cultures advocate using psilocybin mushrooms in pursuit of spiritual experiences assisted by an experienced guide. Indigenous cultures in South Africa use fermented grains to make traditional beer that is passed around at traditional ceremonies as a way of communing with the ancestors. Religion can thus serve either as a risk factor or a protective factor with regard to exposure to substances and the potential for subsequent addiction, depending on the context.

6.3.1 Protective benefits of spirituality

While much research has been done on the links between religion, spirituality and addiction or recovery, particularly in the 1990s, it has tended to focus on a few core themes. Firstly, it has been proposed that having a spiritual component to one's life, and having some form of religious faith, may play a protective role in various mental and

physical health issues (Cook, 2004). Other findings have shown an inverse relationship between religiosity and substance use/abuse, reduced substance use among those practising meditation, and the protective effects of twelve-step group participation during recovery (Geppert et al., 2007).

There is a well-established relationship between moderate use of substances and religiousness, where highly religious people (at the extreme) are consistently unlikely to abuse drugs and alcohol (Chappel & DuPont, 1999). This suggests that if one has a strong moral code to live by which discourages substance abuse, that code will support one in maintaining an addiction-free lifestyle. Programmes with a spiritual component such as Narcotics Anonymous (NA) and AA are extremely popular, particularly in the U.S., and there is evidence that they are effective (Fiorentine, 2000; Fiorentine & Hillhouse, 2000; Heinz et al., 2010; Heinz et al., 2007; Kelly, 2017b; Najavits et al., 1996). It can be considered that they provide such a strong code to live by.

In terms of other well-being and health issues, research shows that greater spirituality correlates with a lower incidence of depression, cardiovascular disease and teenage pregnancy, and a higher level of global functioning (MacKinnon, 2004; Pargament, 1997; Pargament & Park, 1997; Zinnbauer et al., 1997). Spirituality has also been considered to offer people a way of dealing with uncertainty (Galanter, 2006), which is significant for those with difficulty regulating affect (such as anxiety, anger and depression) and interpretation (such as those on the autistic spectrum or those who cannot read social situations accurately, as discussed in the chapter on empathy). In times of stress, religious and spiritual factors are considered to be protective in the face of substance abuse and to contribute to the efficacy of both recovery and treatment interventions (Borras, 2010; Carrico et al., 2007). Strong religious belief has also been associated with a decreased likelihood of reusing needles/syringes (Staton et al., 2003) and has been considered to be a protective factor against drug addiction as well as a component in recovery (Borras, 2010).

In short, having a religious/spiritual component in one's life has been found to play a mediating and protective role in terms of vulnerability to addiction.

6.3.2 Spirituality and recovery

Recovery is a process in which an abstinent individual embarks on a positive trajectory as the result of changes in their choices and behaviours (Wiklund, 2013). It is not only the absence of substance abuse but the return to wholeness and health (DiClemente, 2013).

To recover, there has to be a profound change in the self and the way the person relates to his/her world — as Marcus (1998, p. 466) put it, a "change of career". This involves re-inventing and re-investing in oneself with a commitment to become who or what one wants to be (Finfgeld, 2002). While recovery is a unique journey for each addict in terms of that person's particular goals, values, traits, skills and opportunities, every person in recovery faces the same challenge of negotiating life's complexities without resorting to their substance of choice (or any other).

A number of researchers (DuPont & McGovern, 1992; Green et al., 1998) have argued that there is a spiritual dimension not only to addiction but also to recovery, and that this dimension relates to the core of the self. Wiklund (2013) described the challenges of recovery in the context of spirituality as having to negotiate meaning versus meaninglessness, connectedness versus loneliness, life versus death, freedom versus adjustment, responsibility versus guilt and control versus chaos. Positive outcomes are seen to provide the motivation as a person journeys through the process of recovery and personal development.

Spirituality has been shown to be a significant and independent predictor of recovery and/or improvement in indices of treatment outcome (Avants et al., 2001; Carter, 1998; Heinz et al., 2010; Heinz et al., 2007; Kendler et al., 1997; Kendler et al., 2003; Piedmont, 2004). The interaction between spirituality and aspects of well-being and healthy behaviour have been found to positively influence the addict's motivation, values and commitment to engage in a process of personal and lifestyle change and manage emotions and stressors (DiClemente, 2006). An increase in levels of spirituality have been measured between treatment entry and subsequent recovery (Borman & Nixon, 1998; Mathew et al., 1996; Pardini et al., 2000), and levels of spirituality may be greater among individuals whose recovery is successful compared to those who have relapsed (Jarusiewicz, 2000). Length of sobriety has also been positively associated with

spirituality (Carter, 1998; Poage et al., 2004), while commitment to a higher power may lessen the severity of relapse episodes (Morgenstern et al., 1997). In retrospective studies, recovering addicts have often reported spirituality as an important component of their recoveries which has helped them sustain changes they have made during their treatment (Flynn et al., 2003; Koski-Jannes & Hanninen, 1999).

One study found that participants' rating themselves high on 'spirituality or religious support' was an accurate predictor of cocaine and heroin abstinence (Avants et al., 2001). In another study, longer periods of abstinence were reported for those AA members who self-reported higher spirituality than for others (Polcin & Zemore, 2004). Green et al. (1998) note:

> The data suggests that some persons in recovery often undergo life altering transformations as a result of embracing a power higher than one's self, that is, a Higher Power. The result is often an intense spiritual journey that leads to sustained abstinence. (p. 325)

Experiencing 'higher power' lightbulb moments akin to spiritual conversion is common in twelve-step narratives and in AA a common narrative is of the 'prodigal son' coming home (to AA) (Koski-Jannes & Turner, 1999).

Filling a vacuum. For many, recovery involves dealing with a spiritual vacuum which they attempted to fill by (ab)using substances (Coleman et al., 1986). This is why turning to a higher power can be so healing and comforting and the spiritual path can provide meaning and guidance for the recovering individual to embrace 'living life on life's terms', as the twelve-step aphorism advocates.

Acceptance. When the need for acceptance (in the sense of accepting things as they are) is addressed, patients experience relief (LaChapelle et al., 2008). In terms of self-acceptance, when people feel themselves accepted as unique and worthy they are free to differentiate themselves as unique individuals (Hayes, 2003). They no longer feel the need to use substances to block out feelings of shame, blame, guilt and other difficult emotions.

Meaning. Frankl (1988) held the view that the need for meaning is the central driving force in human existence. Religion offers a new and stable meaning structure to addicts,

an aspect which is central to their recovery (Fredriksson & Lindstrom, 2002; Rehnsfeldt, 2005; Wiklund, 2013).

6.4 THE MECHANISMS OF RELIGION AND SPIRITUALITY IN ADDICTION RECOVERY GROUP WORK

According to Grodzicki and Galanter (2006), in comparison to research in the fields of general psychiatry and medicine, the field of addiction is full of references to spirituality. In terms of recovery, this is because of the meaning aspects: the sense of connection to something bigger than oneself, as well as the shared belief in helping each other (Laudet et al., 2006). Spirituality is about connection — in contrast to the isolation associated with addiction (Hari, 2015).

Connection is encouraged in an addiction recovery support group. It is part of social learning. This mode of connection implies a sense of grace and of something profoundly meaningful occurring when one recovers and transforms oneself in the presence of others engaged in the same process. Carrico et al. (2007) and Moos (2008) propose that the following components of religion and spirituality exist in the group and combine to impact on the changing identity of the addict: supportive social networks, shared beliefs and goals, positive social pursuits, interacting with role models, developing skills in coping, self-efficacy, self-confidence and emotional regulation.

It is important that the addict chooses to join a group because he or she genuinely wants to, otherwise there is likely to be little benefit (Moos, 2008). Many addicts enter rehabilitation to please others (Snoek et al., 2016) or as the result of a court decision, with predictably dismal results (Brown, 2010; Werb et al., 2016). It is important that the approach of the group fits well with the philosophical, spiritual and religious (or not) outlook of the participant, otherwise he or she might feel a sense of not being part of the group, of pressure to conform, or that he or she is not fully accepted. A religious or spiritually-oriented group for someone who is not that way inclined would not work, and vice versa. This may in part be a reason why people berate AA, saying it does not work (as discussed in Chapter 3, Models for recovery in a group context) based on the way a particular group they have attended was conducted. However, there are sufficiently

diverse recovery groups for people to be able to find the one(s) that suits them best. One size — even one group — does not fit all.

6.4.1 Example: Spiritual mechanisms in the context of Alcoholics Anonymous recovery programmes

Twelve-step programmes stress the importance of spirituality in recovery (Mustain & Helminiak, 2015). The twelve steps of Alcoholics Anonymous mention a higher power, God, or spirituality explicitly in seven of the steps, as shown in bold in Table 6.1.

Table 6.1 The twelve steps used by Alcoholics Anonymous (1989)

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

6.4.1.1 The importance of a higher power

Alcoholics Anonymous has been considered to be an effective and cost-effective public health resource which is able to mobilise therapeutic mechanisms and offer these services to the communities in which they are located (Kelly, 2017a). In 1990, the United States'

Institute of Medicine called for research on recovery through the AA programme, including AA's claim that recovery is achieved through a spiritual awakening (Kelly, 2017a). It was found that this was not always the case (Krentzman et al., 2013). This was seen in the recovery experiences of many AA members as well. As a result, in the second edition of their Big Book (AA, 2001) AA acknowledged that this conversion experience was not necessarily the way that all people recovered but, instead, that many recovered through what it called a spiritual experience of the 'educational variety' — a more gradual shift, albeit still 'spiritual' (Kelly, 2017a). AA's co-founder, Bill Wilson, explained the role of spirituality in AA's success pragmatically: "Our ideas did not work. But the God idea did" (AA, 2001). This suggests that while spirituality is difficult to define, the concept of 'God' or a 'higher power' has played a powerful role in successful recovery in AA. In his research on AA, Kelly (2017a) wrote that by embracing an all-inclusive spirituality which allows each participant to identify or define a higher power on his or her own terms, many more people have been able to find a recovery space in AA than previously. AA has even gone so as far as saying that G.O.D. can stand for 'Group of Drunks' if that is what works for a member, while "good orderly direction" has been suggested by Julia Cameron (1992), underscoring the non-prescriptiveness of the twelve-step interpretation of God.

6.4.1.2 The steps

A coherent self. When an addict embarks upon recovery and first attends a recovery group, his or her sense of self is often fragmented and life feels unmanageable — as indicated in the first step of the programme. The first aim of the programme is thus to build up a coherent sense of self (Knack, 2009). Certain parts of the twelve-step programme address this with opportunities in the group for participants to share anecdotally and for newcomers to listen and learn from the old-timers' experiences. Newcomers identify with these narratives and realise that, while they are individuals, the downward and destructive trajectory of addiction is universal.

Surrender. The second and third steps of the programme refer to surrendering to a higher power. The conception of higher power and God gives hope, purpose and direction. The process of hearing others admitting their wrongs and of their journeys of turning their

lives over to a higher power, in an accepting atmosphere, allows newcomers to listen, reflect and identify with their own wrong-doings, owning them for the first time through beginning a process of introspection. The irony is that as they turn over their lives, they begin to take responsibility for themselves.

Moral inventory. The fourth step involves doing a strict and fearless moral inventory. This tool of the twelve-step movement creates awareness of the self. Self-examination of both one's positive and negative traits is part of this and should be done in writing. It must be done honestly and only when the person is genuinely ready. It can be repeated as often as necessary, too.

Admitting wrongs to others. This inventory is then shared — sometimes with a sponsor. This is step five. The point of this is to build up trust in another in an honest, open and vulnerable way. This is often the first experience of being known and sharing one's true self with another, so the addict may feel vulnerable and the person chosen to share this with needs to be accepting and understanding. Together, they work on identifying problematic and destructive behaviours and attitudes that the addict can work on and eliminate, as well as strengths and competencies that can be used to build a new life. This relationship brings an experience of emotional trust and intimacy. This template is then applied to other relationships in the addict's life (steps eight and nine). It can bring a great deal of relief to the recovering addict to learn how to relate honestly and openly. The cultivation of trust and closeness in relationship with another overcomes the isolation of addiction. This produces a confidence and stability which, in turn, supports the intention of the person to live a better, more genuine life (Mustain & Helminiak, 2015).

As addicts take personal responsibility for their behaviour and see themselves more realistically — and more hopefully (also through the eyes of the person they have shared with so honestly, and having a positive experience with this) — they begin to see others more realistically too. This happens both inside and outside the group. Admitting their wrongdoings to those they have wronged, and taking responsibility for these wrongdoings, is immensely freeing, enabling the addict to know they have done the right thing and can continue their recovery without bringing the shame and guilt of the past with them.

As they are welcomed into the group, their anxieties lessen and they become better able to enter other social situations with the group experience serving as a reference for managing their emotions. Slowly, participants who could not sit still during a meeting are able to not only sit through a meeting and concentrate but look others in the eye and connect meaningfully (Mustain & Helminiak, 2015). This is the twelve-step idea of 'relatedness to others'.

In time, the addict speaks in the group. The AA dictum "take the cotton wool out of your ears and put it into your mouth" is explained to newcomers who are not yet ready to be open and learn. The old-timers teach the newcomers, providing hope and purpose for all participants. The old-timers' progression to this role is important as it validates the spiritual transformation which underlies recovery, enabling one to meaningfully assist others (Glickman et al., 2006). From listening humbly to others over time, new members learn that they have something to share that is worth listening to, and the dynamic becomes reciprocal (Mustain & Helminiak, 2015).

The spirituality of the recovering addict thus develops through practising the twelve steps, which in turn produces personal transformation. The steps are repeated as needed through the process of recovery.

Rio, the addiction counsellor in the group who also facilitated Narcotics Anonymous (NA) groups comments on his approach to teaching the twelve steps:

> *It's teaching them a programme of recovery and there are steps to that programme, starting with surrender, starting with powerlessness and then proceeding along where we get into being able to reflect on oneself, and forcing oneself to self-reflect … something that you thought gave you power to live, and something that you thought made you powerful, but in fact, destroyed you. You start to realise now that you are powerless over that thing and if you use that thing, it will destroy you. So we teach that. We also move on to showing people the value of reflecting on how you are living … and being able to see what you do in your life creates the good and the bad and that before you looked to blame other people. … It's looking at the kind of victim you create of yourself and seeing that you are responsible for most of the problems in your life. … And so, self-reflection is very important. And learning to forgive other people is very important. Learning*

to ask for forgiveness is very important: learning to humble yourself and see that you are capable of making mistakes and deserve to be forgiven and that other people are capable of making mistakes and that they need to be forgiven. And then going further into getting people to practise these principles of surrendering and looking at personal change on a daily basis, looking at the things in life they can and that they can't control, asking for help to assist with something — whether its God, whether it's the universe, whatever it is that you feel comfortable with — you need to let those forces deal with those issues that you cannot deal with. You are not alone. Life doesn't start and end with you. So, it's moving people away from that isolated, self-infused life to one where you can ask for and accept help, you reflect on your life, you forgive, you ask for forgiveness, and you practise the cycle in all aspects of your life so that you gradually become more spiritual in the way that you live, which is a guarantee that you are less and less likely to relapse.

This describes the spiritual philosophy and approach to the twelve steps as lived and taught by someone who recovered this way. The incremental steps involved in moving away from the person the addict was, towards all that embodies being an unselfish, responsible, humble, human being, are clear. We see that someone in recovery is so much more than someone who has stopped their substance of choice, but is actually choosing to be the best human being that they can be through the development of a variety of strategies and competencies.

Good mental health is based on an integrated and stable psyche, which produces the ability to regulate emotions. A connection between mental health and spirituality is noted, as the findings below indicate.

6.4.1.3 Research findings on spiritual aspects of AA compared to other modes of recovery

Much of the research on AA has been conducted in the U.S., as is reflected by the observation that only one of 57 references in Kelly's review (Kelly et al., 2017) is from outside the U.S. Research is sparser in Europe, where AA is less commonly considered a standard element of a continuing-care system and practice, and sparser still in South Africa, where two articles were found referring to AA: one by London et al. (1998) and

the other by Kasiram and Jeewa (2008). Research was found on AA where it was linked to support for those with HIV (Levy & Storeng, 2007; Robins, 2005).

Project MATCH. Project MATCH (conducted from 1989–1997) is the largest randomised trial of a spiritually-based treatment programme to date. It involved 952 subjects in outpatient care at five sites and 774 aftercare patients. It compared cognitive behavioural therapy, motivational enhancement and twelve-step facilitation, including AA, and showed that these three interventions were equally effective but not to the extent to which it was assumed (Project MATCH Research Group, 1998a).

Project MATCH showed that spirituality is not a significant factor for highly addicted participants and that AA's mechanisms are predominantly social, emotional and cognitive (Project MATCH Research Group, 1998a). This was contradicted by research in which the spiritual side of the twelve-step programmes was found to be helpful in maintaining abstinence (Fiorentine, 2000; Laudet et al., 2003). Fiorentine and Hillhouse (2000) found that the important spiritual variables in maintaining abstinence are frequent participation at meetings and surrendering to a 'higher power'.

Project MATCH measured the spirituality of participants using questions relating to formal religious behaviour (such as 'reading holy scriptures' and 'attending religious services'), which for Kelly (2017a) may have been a limitation in terms of its not being the sole measure of religiosity. Questions relating to meditation and prayer, which are advocated in the eleventh step, revealed that spirituality was a significant mediator of AA's benefits (Kelly, Humphreys, et al., 2017). Kelly (2017a) found that compared to other mediators, spirituality was only significant among those addicts with more severe problems. Other mediators which were also found to aid recovery significantly included coping with high-risk social situations, support for total abstinence, managing emotions, reducing the symptoms of mental illness, and moving from one social grouping (practising alcoholics) to a new network of abstainers or low-risk drinkers.

Tonigan et al. (2013) found after analysing the same set of findings that in five of the six studies, spirituality partially clarified the link between AA involvement and improved abstinence, as did AA involvement with abstinence, commitment to AA practices and client motivation in the form of spirituality, twelve-step networking and support (Laudet et al., 2000; Laudet et al., 2006; Tonigan et al., 2000). Length of involvement was

associated with greater life satisfaction, as was AA attendance (Emrick & Tonigan, 2004). Montgomery et al. (1995), however, found that the extent to which clients attended AA was less important than their meaningful involvement in the practice. Piedmont (2004) evaluated the results of abstinent drug users who participated in an eight-week spiritually-oriented programme, and found that those who had higher scores on spirituality upon entering the programme scored higher on well-being and psychiatric symptom reduction upon programme completion. This suggests that practice, community and identity could be salient elements in addiction recovery, along with spirituality.

Most evaluations of AA show a correlational, rather than a specifically causal relationship, between AA and drinking cessation, as those attending meetings would be more likely to give up drinking than those who do not. In a study of untreated alcoholics, those who attended AA showed greater improvement than those who did not, and the number of meetings attended in the first three years was a significant predictor of sobriety at the eight-year mark (Humphreys et al., 1997)

According to Wilcox et al. (2015, p. 382) there is "now strong evidence that attending AA predicts increased alcohol-abstinence at a later time for many".

Spirituality is considered to be one of the specific change mechanisms in AA, along with social support and increased self-efficacy. Tonigan et al. (2013) explained that the idea of loss of control and handing over one's power would be expected to result in lowered self-efficacy; however, the opposite is true and AA participants integrate the apparently contradictory message that should they drink they will experience a loss of control. This powerful paradox facilitates abstinence.

6.4.1.4 Understanding the role of spirituality in addiction recovery

Peteet (1993) stated that twelve-step programmes help recovery by addressing specific needs, including appropriate identity, integrity, meaningful inner life and/or interdependence. It has also been shown that integrating twelve-step groups into a general psychiatric unit yields positive results (Goldfarb et al., 1996). In addition, integrating biomedical and spiritual options produces more positive results overall if patients are spiritually inclined (Dermatis et al., 2004).

AA's commonly understood position is that spirituality and spiritual virtues (e.g. honesty, gratitude and altruism) can potentially counter the desire to use alcohol/drugs and encourage a new way of living. AA's open and 'non-denominational' framework, in which people of varying spiritual persuasions can find direction and assistance with the existential issues involved in addiction, may actually serve as a valuable example for European clinicians as well as African ones.

This resonates strongly with the view of Rio, one of the addiction counsellors in the group, who recovered via a twelve-step programme and holds a senior position in one of the local Narcotics Anonymous groups:

> *The 12-step programme that we use contains many spiritual principles that are completely opposite to the way we used to live … by practising as much of these principles as we can … a dishonest person can become honest, an uncaring person can become caring, an unloving person can become loving, a self-centred person can become humble. So, they start to see that we can become better human beings and learn to deal with life on life's terms. And when we are in recovery we have to live these principles of being better people and other addicts can see that this life is not just words that we talk about but that it's actually lived.*

6.5 MECHANISMS OF RELIGION AND SPIRITUALITY AND THEIR ROLE IN PERSONAL TRANSFORMATION IN THE CONTEXT OF THE ADDICTION RECOVERY GROUP

This section looks at religion and spirituality in the group itself, focusing on how the rituals, structure, rules and facilitation of the group impact each member's transformation. The moral code of the group and the set of practices of the group (religious mechanisms) via the practice and enactment of various rituals within the group facilitate spiritual development within group members, which positively influences their recoveries.

My belief is that the spiritual aspect of existence can be fostered through the group's practice (of recovery) which entails rules, rituals and, often, religious aspects. In other words, through its religious practice the group develops the spiritual qualities of its participants in those who wish to see them as such.

6.5.1 Rituals

The word "ritual" comes from the Sanskrit *rta*, which refers to both "art" and "order". Watson-Jones and Legare (2016, p. 42) noted that

> like all real art, ritual provides organic order, a pattern of dynamic expression through which the energy of an event or series of events can flow in an evolutionary process toward larger meaning or a new stage or level of life. (p. 42)

Rituals continue to be performed by people living in highly modernised and technologically advanced, multicultural and multi-ethnic cities, fulfilling physical, psychological, mental, social and spiritual needs. In general, rituals provide a template to guide our emotions and actions in particular situations. They bring a sense of familiarity, predictability and order to life — a complete contrast to the chaos of addiction. They thus play an important role in the recovery group.

Rituals in twelve-step programmes such as AA serve three functions (Rasmussen & Capaldi, 1990):

1. The reading of prayers and literature reaffirms the organisation's collective history, traditions and world view.
2. Members' performance of and listening to rituals create a sense of mutual identification which emerges from active participation.
3. Listening to others teaches the listeners how to speak and think about recovery as well as how to recover. Taking part in an AA group's rituals reinforces that group's orientation, unity and modes of communication. Denzin (1993) notes that participants of AA reaffirm rhetorical rituals that have the potential to reinforce recovery by jointly enacting a collective ritual symbolising identification, orientation and communication. Meaning is shared through stories and literature and these rituals "transform the member into a talking subject" who draws their power from joining in this narrative ritual.

The addiction recovery group in this study observed the following rituals at every session, in terms of the structure, rules of engagement and facilitation of the group.

6.5.1.1 Structure

Fixed and familiar venue. The group always met in a large room at the same clinic where all of the participants had completed their inpatient rehabilitations. The space was thus imbued with the continuity, care and constancy that participants had experienced at the clinic.

Signing the register. The group began with the same ritual: signing a register of attendance, a *rite de passage* of entry. Participants sat on chairs in a circle so that all participants were able to see each other.

Bounded times. The duration of the session was always bounded: on Saturday the group started promptly at 10.15 am and finished promptly at 11.15 am; on Thursday the group started promptly at 5 pm and finished at 6 pm. This showed respect for participants and created containment for the group.

Welcome. The meeting always began by welcoming everyone to the group and outlining the purpose of the group: a free, bi-weekly aftercare group to support those who had been treated at the addiction unit at the clinic in their recovery. This provided a welcoming atmosphere for participants and established who the group was, and was not, for.

Introductions. Participants took turns introducing themselves, saying their name, their substance of choice and the length of time they had been sober or clean. This ritual conveyed the belonging of members and welcomed new members. It recognised the commitment and experience of outpatients who were further down the road of recovery — who were given precedence to speak — and established the role of the newcomers as being there to learn. The facilitator explained the importance of the participation of a psychologist and addiction counsellor as facilitators of the group.

6.5.1.2 Rules of engagement

The rules of engagement within a group are intended to make the group a safe — and even sacred — space, different from other groupings and spaces. The following ground rules were developed by the group and were added to when necessary. They were shared

with newcomers to explain what was expected of them in the group, and served to remind all members of the rules they had agreed to follow.

1. Confidentiality: What is raised in the group stays in the group — leave other's names and identities behind in the group, but take the learnings out with you.
2. Each person has a different path of recovery — we are here to support and not judge.
3. People may give their phone numbers to others in the group. We all have different life situations, and so it is up to each person to give their number to whomever they wish to, or not. And if they are called, and it is a bad time, to feel free to say so and practise their assertiveness skills. Recovery begins by saying yes to myself.
4. Start and end the group on time to practise keeping your word and focus, and being there for others — which is part of recovery.
5. Telephones off unless there is an emergency and people need to be called (there are some SAPS members who come to group while on duty).

6.5.1.3 Facilitation of the group

The group facilitators followed a predictable routine, which brought order and calm to the group. They went around the circle beginning on their right and invited each outpatient participant to say as much or as little as they wished, focusing on their recovery. Each outpatient was given an opportunity to speak, but they were free to decline if they did not wish to. The facilitator acknowledged victories and opened up areas for discussion and support from the group as issues emerged. The group applauded each person when they had finished and acknowledged their commitment to their recovery.

The facilitators needed to be mindful of time in order to ensure that each person was given an opportunity to speak during the time available. For this reason, the time was signalled to the group throughout the hour to encourage each speaker to not speak for too long out of consideration for others; overcoming the selfishness of addiction is part of recovery. The facilitators modelled keeping to time as a way of giving one's word and keeping it — another important learning in recovery. If there was time, inpatients were offered the opportunity to speak.

The group closed with all members standing, holding hands and saying the Serenity Prayer together:

God, grant me the serenity
to accept the things I cannot change,
the courage to change the things I can,
and the wisdom to know the difference.

When participants were asked what it meant to them to say the prayer, their responses included the following comments:

> *It's a good thing.*
> *People who pray together stay together.*
> *It's an international, universal prayer.*
> *I would feel cut off if I didn't have the prayer — like the pastor ends with a prayer, we close the group off with a prayer. I would feel that meeting was incomplete without a prayer.*
> *It's like saying that we've done with this week, now grant me the serenity to cope with the week ahead until our next meeting.*
> *I feel thankful.*
> *It is integral to recovery.*

It is interesting that none of the comments suggested that the importance of the prayer was to be more religious or closer to God, but instead to be closer to the spiritual values of community, fellowship, universality, wholeness, humanity, meaning and authenticity.

In the structure of the group one can see the various rituals which combine to constitute the space dedicated to the participants and their recoveries. Rio commented:

> *The other thing that helps people recover is to give them a discipline, a programme, a structure that they are able to follow to cope with their disease. Part of this is in the structure of the group.*

Watson-Jones and Legare (2016) hold that rituals serve four core functions: they (a) provide reliable markers of group membership, (b) demonstrate commitment to the group, (c) facilitate cooperation, and (d) increase social group cohesion. The capacity to engage

in ritual is a psychologically prepared, culturally inherited behaviour geared toward facilitating social group dynamics.

Rio believed that the rituals and programme of recovery do not have to take place in the context of a recovery support group for members to transform, but could happen equally well in a religious structure:

> *We find that people who come to NA and then go to church are clean and they get transformed through church because the church is able to do that. ... But with institutions who independently have a role to play, in guiding them, they can thrive. ... And so, for the addict, I think it's that basic discipline or structure that's required or else you are just going to struggle. And I think they actually thrive in these kind of environments because there is something that is forcing them to use themselves in a positive way and focus and be something else other than what their mind is telling them to be.*

Rio saw the possibility for the moral development of the person with the organised support of participating in any institution that has a behavioural and moral code that the person engages with and takes seriously.

It is seen then that addicts do not necessarily need a recovery group in order to recover, but they do need a community of other people and a strict code to follow and to guide them. In addition, personal transformation needs organisational (institutional) support in the form of rules and rituals, and human support in the form of acceptance of the central aspects of who that person is.

6.5.2 Impact of participating in the group on participants' religion and spirituality

This section explores the religiosity and spirituality of group members by examining their perceptions before, during and after their participation in the recovery group. Two things stand out: the process of their emerging spiritual development over the course of their recovery journeys; and the fact that there were both spiritual and religious aspects to their recoveries.

6.5.2.1 Participants' spirituality and religiosity before joining the group

As discussed earlier in this chapter, research has found that spirituality can play a protective role against addiction. Only one participant, Karen, mentioned having a religious aspect to her life before entering recovery:

> *When I went through all those years of addiction, I was an on-again, off-again church goer, and I was a Sunday Christian. As long as you got to church on a Sunday you were fine.*

Karen's description is characteristic of the selfish and superficial approach common to those suffering from addiction: her engagement with religion was limited to attending church on a Sunday, which she believed 'ticked the box' for the week. Underlying this, however, was a belief that God had abandoned her:

> *But personally, through all the years of my relapses, and all the years of coming to group, I've always thought that God turned His back on me. And I was angry. And when my dad died, I was angry. And it's taken me a very long time to realise He didn't [turn His back]; He didn't change. I turned my back on Him.*

Through the trajectory of her recovery, which consisted of eight relapses, Karen learned and matured from relapse and her relationship with God grew and deepened. She was able to connect the reason that she had withdrawn from God to His not saving her father, and she saw how she had turned her back on God to punish Him. Realising her own conditionality and making this connection allowed her to open to God and realise and experience His constancy in her life. The insight for her was that God had never left her, but that it was she who had turned her back on Him. In the process of doing this she developed as a person, becoming far better able to look beyond herself.

6.5.2.2 Impact of group work on participants' religiosity and spirituality during the group

Some of the participants' experiences of religiosity and spirituality during and because of the group are described in the following quotes:

Nikhil, in a moving statement, articulated the transcendent and relational quality he experienced:

> *When I sit in church, and the pastor will say, "Can you feel it? Can you feel it?" And then I think to myself, "I feel it more here, in this group than sitting in church." And that's the honest truth. I feel it here more, than sitting with a thousand people in church. I sit in my group and I feel it. I think about it every time I sit in church: I ain't feeling nothing. But I feel it when I sit here. And that's just how I feel: it's not gospel, it's not anything; it's the heart that speaks and this works.*

The richness, meaning and fullness of the group experience was also expressed by Vega:

> *I'm fed here, and it's about my soul being fed.*

This relates clearly to the 'emptiness' experienced by addicts and their attempts to fill it through addiction, which is described in the literature (Appel & Kim-Appel, 2009; Birchard, 2004; Green et al., 1998; Okundaye et al., 2001)

Vega elaborated by describing where the feelings of both emptiness and of being filled came from:

> *With meetings, and having a support network, I feel filled. Speaking for myself, the emptiness comes from that lack of connection with other people. I never ever felt close to anyone or felt that I could say what I wanted to say to people. It left me with feelings of loneliness and feeling alone, but with recovery and seeing the gifts that come my way — like, I have a job, I have a family, I have a car, I have all this stuff going in my life, and supportive people — it fills up that space, and the self-esteem — the confidence — it all comes back and fills the void, whereas before, it was using the drugs that tried to do that.*

Here, we see the spiritual qualities of relatedness, authenticity, gratitude, self-knowledge and meaning and a sense of purpose in life.

This experience is captured by recovered addict and journalist Barney Hoskins (2017) as follows: "Addiction, I found, wasn't a by-product of drug abuse. It was a false filling-up of spiritual emptiness."

Vega described how it was the acceptance and connection from belonging and being in recovery together that she felt filled her. Many of the spiritual qualities discussed earlier were reflected in her words as well:

> *We have a respect for each other even though we are all different and have all been through things together, but in our own different way. And we don't judge each other for it. ... Everybody's recovery is individual: my recovery wouldn't work for someone else, and someone else's recovery wouldn't work for me. ... I couldn't ever leave that 'cause I gain so much from that support system and, to walk away from it, I would leave myself with an empty void.*

This expresses beautifully the relatedness and humanity of the group in terms of their respect, acceptance and commitment to each other. This resonates with Carl Jung's (1963) "protective wall of human community" as recovery is attained and sustained through cognitive and affective changes and additions to the addicts' recovery repertoire by participating in a recovery-focused supportive social structure.

Vega continued:

> *Some people do leave, but it's very, very few who actually make it [on their own] — they need that connection with other people.*

The flexibility in AA's later position on the role of God, or a higher power, in recovery is shown in Jashwin's comment about the twelve steps:

> *The twelve steps talks about the God of your understanding, but if for you that's the Bible and religion, and that will do it for you, give it a go.*

Implicit in this attitude is an invitation to participate in life and the participant is encouraged to try things out and see how they suit them, and discover more about themselves. The world is seen as full of possibilities to be explored — in contrast to the addict's narrow and confining experience of the world of addiction (Kemp, 2011)

This was echoed by Karen:

> *Accept God, inner strength or a higher power in your life. It gives you determination. Helps you let go and let God.*

She had come a far way from doing it all herself, feeling alone and disconnected.

Belief

Karen experienced her faith as private and personal. She believed God was with her continually, placing her where He wanted her to be. She had come a far way from being angry at Him and turning away, to now surrendering her life fully to Him. It was this surrender that brought her life its deepest meaning and value.

> *I don't think I would be in this meeting, talking, if God didn't want me here. I don't come across like it, but I am a very religious person and I have a bond with God that's growing. My recovery has taught me that God didn't turn his back on me; why should I turn away from God? And it's been a very painful process to turn around and look at him again. But I wouldn't be here if he didn't want me to look at him again. That's what my journey is about.*

Her sense of purpose of her life, and its truth for her, were found in how she made sense of God in her life through her struggle with her addiction and her recovery. She believed she was living God's plan by preventing another person from becoming an addict.

> *"Someday, somebody, something": those are my three words at the moment. Someday somebody might listen to something I say. If I can change one person's life and stop them picking up a drink, then I did something right. It's all I want. If I can help one addict not pick up the next drink, I've done all I was sent to do.*

Karen's experience of the meaning of her life, derived from her personal struggle with addiction, is seen in these words. She had worked her own pain and difficulties into a mission and a gift that she chose to share with other addicts on her path. This gave her struggles value as the lessons she had learned would help others. These were spiritual values, but were based on her religious devotion to God.

Spero made sense of his struggle in a similar way, finding meaning and purpose in his pain:

> *The suffering that God has sent me is for my good and I should be glad of the pain as it is making me into a different person, and here in the hot crucible of the relationship is where my growth is going to come.*

He, too, found that in the vulnerability of human connection came his growth and meaning. The spiritual qualities of self-awareness and self-knowledge, meaning, purpose, authenticity and relatedness, as well as humanity are evident here.

McKenzie shared:

> *I owe my recovery not only to my friends, but also to God. Without Him I couldn't have done this. If I look at the way I was dopping* [Afrikaans for drinking alcohol] *to the way I am now, maybe I'm not a better person but I feel better, healthier. Right is right and wrong is wrong; there is no maybe. There is no grey.*

A sense of morality, values, truth and clarity is evident here, as well as an implicit sense of relief and happiness underlying their words. Meaning is found in the transformation of their suffering and in the notion of helping others.

Acceptance

Karen expressed the acceptance that group members experienced from each other during moments of transcendence and relatedness in the group:

> *It doesn't matter what your colour, your sexual preference, your religion, what party you support, what soccer team — I mean, we've had jokes here about Kaiser Chiefs and the Sharks and there's no judgement.*

Rituals

Alexa, when asked to comment on the rituals in the group, said that they provided her with a unique opportunity to share and reflect on her own and others' recoveries. The spiritual qualities of humanity, relatedness, wholeness and gratitude are evident in her words:

I don't think we'd have an opportunity like this again to think in a group about our recovery. A lot of stuff comes out that we've forgotten about. You can go back now and say that's what happened in the group. And it comes back to you. And be grateful.

Thus, the existence of the group provided the participants with a space and place to express themselves where their experiences were mutually valued, thus allowing them to consolidate the lessons learned from their recoveries.

Several aspects of spirituality emerged through members' participating in the group which helped to develop the spiritual and religious aspects of their lives, thereby acting reciprocally in support of their recoveries. The provision of routines and rituals facilitated deeper connections for participants with themselves and with each other, as well as providing them with social learning mechanisms to aid their recovery and imbue their lives with meaning.

6.5.2.3 Impact of group work on participants' religiosity and spirituality after the group

Something intangible happened through the group process that affected its participants to the extent that others could see it. Nikhil expressed it like this:

When I come home from group, having had a chat with you guys, refreshed, renewed, rebooted, even my wife notices …

The feeling of grace, which allowed participants to cope better and brought a sense of truth and meaning into their recoveries and a greater sense of their own value was described by Karen:

My whole life is blessed now. I still have my issues, my life is up and down, I have my mom who drinks too much and whose health isn't great, I still have tension at work with people I don't get on with … there's so much going on in terms of ups and downs and life's good.

Through her faith, Karen was able to embrace her life, cope better without relapsing and find a meaning and truth to her life which stabilised her recovery.

Karen's words resonated with Rio's:

> *Life is about having good experiences as well as bad and it's about knowing how to embrace life in that way. So it's about pitching up, and living life and moving from a place of never being very aware of what the consequences were for oneself and others to one where you are more conscious of what your actions are.*

The feeling of being blessed, described by Karen, was echoed by Alexis with specific reference to her children:

> *I feel that I am blessed to have my kids and that my life is for them. My staying recovered means something to them. ... So for me that is important — that I have to prove something to myself and to be better for them. So for me it's not about God and going to church but about being a moral person. And everything is definitely improving.*

Alexis had found a meaning and purpose to her life and the basis for being a moral person. This is what her spirituality and recovery provided for her.

6.6 CONCLUSION

This chapter has explored the roles that religion and spirituality played independently and together within the addiction recovery group, as well as within the lives of the individual addicts on their unique paths of recovery. The structure, rules and rituals of the recovery group in this study were discussed in terms of their role in facilitating spirituality in the group, bringing richness and greater meaning and fulfilment to the lives of those who embraced them and thus promoting their recovery.

The following chapter discusses aspects of the participants' emotional transformation, focusing on different mechanisms that emerged from the data that the group provided in order for its participants to work with the emotional aspects of their recoveries and thereby sustain themselves.

CHAPTER 7
PSYCHOLOGICAL MECHANISMS: THE ROLE OF SHAME IN ADDICTION AND RECOVERY

"Our feelings are our most genuine paths to knowledge."
— Audre Lorde

7.1 INTRODUCTION

The previous chapter discussed applicable aspects of spirituality and religion, and their roles within the recovery group. There are a number of psychological aspects which also play a role in addiction and recovery, including shame, anger, honesty, empathy and mentalisation, and self-esteem and self-worth. This chapter looks at the many aspects of shame which came through strongly in the findings — resonating with the literature — and the mechanisms used to deal with shame in the recovery group.

It is likely that every person has experienced shame. Shame is considered to be a universal emotion that is amongst the most painful of all human experiences in any culture and exists at the centre of an individual's emotional life (Ho et al., 2004; Lewis, 2004). It is often at the core of an addict's identity. Shame emerges from our earliest interactions and can be reinforced through frequent and intense experiences. If shame of one's own needs becomes internalised, it becomes a condition in which a person feels flawed at her very core. She experiences a 'badness' about herself that can include feelings that are hard to tolerate and articulate. Consistent with this interpersonal and intrapersonal approach, various writers have theorised shame as an experience of total undesirability of the self (Lewis, 1992; Tangney et al., 2007; Tracey & Robins, 2007).

This chapter explores the aetiology and nuances of shame through psychological, psychoanalytic and social science literature, examining how it arises in the individual through relationship and lies at the bedrock of our identity as human beings, often silenced and disguised by other emotions. The chapter investigates the relationship between shame and addiction, and the healing of shame through the mechanisms that occur in an addiction recovery group.

7.2 UNDERSTANDING SHAME

The *Comprehensive Dictionary of Psychoanalysi*s (Akhtar, 2018, p. 264) defines shame as:

> a painful experience which can be broken down into five components: 1) collapse of self-esteem; 2) feeling of humiliation; 3) rupture of self-continuity, whereby what one was, in one's mind, a moment ago is experientially lost; 4) sense of isolation and standing apart from the group, and 5) feeling of being watched by critical others.

Shame is an emotion called forth by our own perceived shortcoming and failure to measure up; it is thus closely aligned to guilt (Deigh, 1983). While guilt is associated with failure or wrong in our actions, shame relates to failure or wrong within ourselves (Nussbaum, 2004); while guilt is 'doing wrong,' shame is 'being wrong' (Orange, 2008). Shame is characterised by an aspect of feeling one's shamefulness is seen by another — which may be an internalised 'other' (Akhtar, 2015). Because of this, shame generates shame and thus compounds itself: when one feels there is something wrong with the core of one's being, one feels ashamed, and then feels shame over being seen to feel shame. The 'shame of being ashamed' results in shame being accompanied by a distinctive pattern of silence about the experience of shame, hiding it or disguising it with another emotion. Shame therefore might often be the driving force behind anger or rage, or might be 'mistaken' as guilt or embarrassment. It has been called "the ugly emotion" (Barnard, 2012, p. 151), because one recoils from beholding it directly, as well as the "hidden emotion" (Hultberg, 1988, p. 109).

Shame has been conceptualised in terms of its various characteristics and mechanisms, including functioning as a primary emotion, as an auxiliary emotion (invisibly driving other emotions), cognitions and beliefs about the self (that an individual is believed to be perceived as by others to be inadequate), behaviours and actions (e.g. running away, hiding, attacking others to cover one's shame), evolved mechanisms (e.g. the physical expressing of submissive and humiliated behaviour, red face, slumped posture, lacking energy), and interpersonal dynamic interrelationships (shamed and shamer) (Gilbert et al., 1998).

Shame is universal

The phenomenon of shame has been found across cultures and throughout history (Shah, 2016, p. 65). Shame has been written about in works ranging from the ancient Indian text, the *Rig Veda* (1500 BCE), to writings by Confucius, St Augustine, Shakespeare and Mirza Ghalib. One of the first scientific accounts of shame was by Charles Darwin (Darwin, 1872), who described the physical manifestations of shame as consisting of confusion of mind and intensity of emotion, downward cast eyes, slack posture and lowered head. He also described the sense of warmth or heat — blushing — occurring in intense shame. He noted that it appeared in human populations worldwide. Shame refers to an all-consuming experience of wordless and total mortification, dejection and depletion of energy (Lindsay-Hartz et al., 1995).

English-speaking cultures consider shame to be linked to experiences connected with a painful sense of the self being considered to be inadequate (Brown, 2006; Lindsay-Hartz et al., 1995). In Japan, in contrast, shame is founded on the negative thoughts and opinions of others towards one, and on one having failed to live up to specific social duties and obligations, rather than one's own evaluation of oneself (McCrann, n.d.). The point of overlap is that shame occurs in social relationships through the critical eye of another. Kaufman (1989, p. 24) has referred to shame as "a taboo of contemporary society".

This chapter focuses on understanding shame within predominantly English-speaking culture, within the South African context, as this is where the addiction recovery group is located, but also bearing in mind that the group itself comprises Zulu, Indian, White and Coloured South Africans, as well as a member from another country. Sensitivity to and respect for different experiences of shame are important.

The need to account more thoroughly for shame has emerged since Christopher Lasch (1979) identified a "culture of narcissism" where he examined the rise and prevalence of this personality type. When examining the underbelly of narcissism one finds insecurity, inferiority and shame (Akhtar, 2016). Shame has only begun to be accounted for more qualitatively and rigorously in the past two decades in psychological and psychoanalytic writing. A wide variety of shame theories, rooted in various disciplines, have emerged (Gilbert et al., 1998; Heller, 2003; Pattison, 2000).

7.2.1 The social origins and nature of shame

Human beings are social creatures and at the heart of our sociality is an interpersonal bond that connects one human to another in a meaningful way (Poulson, 2000). In South Africa it is expressed as *ubuntu* where it is understood that 'a person is a person because of others'; a person becomes a person through relationship with others. The need to belong and have meaningful human connection is fundamental to the human experience. Relationships are reciprocal and as the individual participates, shares and gives, they also receive feedback in the form of meaningful approval or sanction.

7.2.1.1 Shame at the bedrock of identity

Object relations theory describes the process of developing one's identity from birth in relation to others through attachment, internalisation and separation from one's primary caregivers. Based on psychodynamic theory, object relations theory suggests that the way people relate to others and situations in their adult lives is shaped by experiences with significant others, especially the primary caregiver, during infancy (Kaufman, 1996).

Fairbairn (1943), one of the pioneers of the theory, explained that when, on an ongoing basis, a child experiences himself as the object of his parent's (or caregiver's) frustration, anxiety or resentment toward him, while having his needs met by the parent at the same time, the child internalises this resentment and experiences his own neediness and dependence as shameful, unacceptable, burdensome, excessive and repulsive (Fairbairn, 1943). The child concludes that, at his core, he is unacceptable (Celani, 2010). Celani (2010) widened this to include the social context by explaining that while being a private object of contempt is unbearable enough, being exposed publicly to the view of others who witness the child as "being hopelessly attached to a demeaning parental shame is simply mortifying" (Celani, 2010, p. 174) In cases where mothers had mutilated their children, Fairburn wrote that the children experienced shame not that they were the objects of mutilation but that others would know that they were (Celani, 2010). It is when seen through the eye of the other that one's experience of shame is at its most acute. It is as if the original experience of rejection is reactivated and even worsened through the eyes of another.

This resonates with Sartre's (1943) view that shame emerges in infancy at the introduction of the 'other' who sees us and judges us; in that moment we become both subject and object. We internalise that critical 'other' and carry it as part of ourselves (Flynn, 2011). Shame creates an aspect of ourselves which perceives ourselves from outside, watching and judging our actions (Shah, 2016).

Kaufman (1996) contended that during the process of identity development, shame is the originator of an individual's poor self-esteem, reduced self-image, questionable self-concept, and a problematic body-image. Shame raises doubts within a person regarding the nature of the person's self and identity, and impacts on their confidence (Kaufman, 1996) and subsequently their relationships with themselves and others. Shame deprives an individual of belonging, mutual pleasure and intimacy, resulting in narrowed and damaging relationships (Adams & Robinson, 2001).

7.2.1.2 Shame as a model of being in the world

Feminist philosopher Sandra Bartky (1990) referenced Heidegger in her description of shame being "a pervasive affective attunement, a mode of being-in-the-world" (Bartky, 1990, p. 85). This resonates with object relations theory and Kaufman's (1996) perspective, which has been discussed, which speaks to the pervasive nature of shame. For Bartky (1990), shame is not so much identifiable as a particular emotion as it is inherent in the way that one responds to the social world of everyday life as well as to events. It colours one's fundamental attunement to one's world. For those who are victims of prejudice, it is an effect of one's subordination in society, a way of perceiving and being in the world that is continually reinforced. Bartky's understanding of the relation between shame and gender in patriarchy strongly echoes Virginia Woolf's, but her analysis of the phenomenology of the emotion of shame is different. For Woolf, used here to exemplify shame, in *A Room of One's Own*, the emotions of shame and anger make themselves felt and thus are available to analysis. But Bartky (1990) called attention to the practice of shaming which is so pervasive that it recedes, as it were, into the hum of the background and is therefore not recognised as it is considered the normal lived way that things are.

7.2.1.3 Shame as exclusion from humanity

Similar points have been made by Bartky (1990), Retzinger and Scheff (2000) and Scheff (2000, 2011). They argue that shame is everywhere and is used as a form of social control though it is not acknowledged as such. Retzinger and Scheff (2000) in fact argue that this partially explains the fact that adults do not use the word "shame" to describe these experiences. Instead we will say that we have been "humiliated" or that we are "embarrassed" or "mortified" (Retzinger & Scheff, 2000). "Shame may be the most social of emotions, since it functions as a threat to the social bond" (Retzinger & Scheff, 2000, p. 84).

An example of this can be found in Van Wyk's (2015) doctoral thesis, which explores adolescent girls' experiences of girlhood in three low-income communities in the Western Cape. Van Wyk (2015) found that the girls experienced their bodies as objects on which their parents and peers often projected their disgust or contempt when the girls did not conform to the dominant notions of beauty and respectability. The participants experienced these projections as shaming and damaging to their sense of self, which evoked feelings of a lack of recognition and being unlovable. From the participants' stories, it was seen that these shaming strategies aimed to regulate normative femininity and 'respectability', which were internalised, thereby preserving the notion of the 'good girl'. This is one example of the insidious and powerful nature of shame and how it keeps social mores intact (Van Wyk, 2015).

Self-esteem comes largely from how we are treated by others. If people are treated in ways which communicate an inferior or outsider status, it has a significant impact on their perception of their self-worth. The stigma of addiction communicates this about the addict. Shame communicates who is unworthy and who is in favour, and is thus a form of overt social control — a way of gaining power over others by being able to judge, control, alter and shape their behaviour. Shaming is also a central feature of punishment, shunning, or ostracism. For Scruton (2000), the real intention of shaming is not punishment but rather to deter people by changing their behaviour for the better (Scruton, 2000).

Bartky (1990) noted that those who are shamed cannot easily draw on their emotions as cognitive touchstones because shame is the condition in which they live. She wrote, "This

shame is manifest in a pervasive sense of personal inadequacy that, like the shame of embodiment, is profoundly disempowering" (Bartky, 1990, p. 85). Bartky (1990) argued that hidden shame exists in our daily lived ways of being as a way of controlling and regulating society with threats of ostracism or rejection for those who cross the line. The threat of this kind of ostracism is intense and can result in a form of social death and social dys-appearance (Leder, 1990).

The social aetiology and amelioration of shame is significant in this study. Shame has been considered as arising from interpretations of the actions of others, such as rejection or threat (Crozier, 1998; Elison, 2005; Retzinger & Scheff, 2000). It has been argued that there is an entwining of our self-perception and others' perceptions of us (Gilbert & Proctor, 2006). Here, being in an inferior position in relation to a more powerful and critical other, whether it is an actual experience or an interpretation of one, can result in an experience of shame (Gilbert et al., 1994; Lewis, 1971). This perception fits with the social constructionist perspectives which emphasise how the feeling and expressing of emotion facilitates the particular experience and enactment of social roles, such as being shamed before, and by, another (Averill, 1985). These roles are determined by the meaning and significance of the specific culture and social situation (Parkinson et al., 2005).

7.2.2 The consequences of shame

There is growing research confirming the notion that having a sense of shame and a devalued self can be indicative of difficulties in relating to others. Some shame-related experiences could be considered functional, and indicative of concerning issues of social status and relationships (Elison, 2005; Gilbert et al., 1994; Retzinger & Scheff, 2000); enhancing and encouraging of individual and group values (Lindsay-Hartz et al., 1995; Scheff & Retzinger, 1991); or regulating physical distance between people through enhanced self-awareness (Probyn, 2004). Some research indicates that the experience of shame is the feeling of intense paralysis, confusion and self-consciousness (Gilbert et al., 1994; Lewis, 1971; Lindsay-Hartz et al., 1995). It has been found that the experience of shame results in social withdrawal and awkward social interaction (Retzinger & Scheff,

2000), as well as increased inability to resist abuse and further shaming in social situations (Bartky, 1990; Gilbert et al., 1994; Gilbert & Proctor, 2006; Seu, 2006).

Coming from a social constructionist perspective, Lynch, in a personal communication in Pattison (2000, p. 74), describes how the loss of words, linked to shame, "accomplishes the exclusion of the subject from the world of social discourse and shared narrative". This reinforces the alienation of the person suffering from shame. They may speak, but their shameful selves and affect remain silently hidden.

Shame is considered fundamental to many experiences of alienation, loneliness, inferiority and perfectionism (Kaufman, 1996). It is considered to play a significant role in many psychological disorders, including depression, anxiety, paranoia, addiction, and borderline conditions, which stem from the failure of the parent to meet the infant's ongoing needs (Kaufman, 1996). Addictions, sexual disorders and many eating disorders are considered to be disorders of shame — which is understandable as they are so intimately entwined with basic human needs. Both physical and sexual abuse also produce shame (Kaufman, 1996).

7.2.3 The experience of shame

Kaufman (1996) succinctly described shame as the most disturbing emotion to the self. Shame is usually experienced most intensely in relation to the group to which one belongs (Doi, 1973, in Shah, 2016). Shame generates shame of itself, yet it activates itself, seeking concealment (Womersley, 2010).

Of the four crisis emotions of grief, fear, anger and shame, shame is considered to be the most difficult to express (Hinshelwood, 1999). The experience of shame feels unbearable because it exposes our early painful negative experiences of our utter helplessness in the face of significant caregivers profoundly and repeatedly failing us. It forms part of the core of our identities — our need for attachment to another to take care of us. It emerges through our first experience of relationship — typically with the mother.

Shame has a pervasive quality — in part, perhaps, because it was formed at such an early, pre-verbal stage of the formation of the self. Morrison (in Orange, 2008, p. 89) writes: "Shame settles in like a dense fog, obscuring everything else, imposing only its shapeless,

substanceless impression." In the presence of shame, we lose the landmarks to ourselves, our lives and each other, like an infant lost in its helplessness and neediness. "It becomes impossible to establish bearings or to orient oneself in relation to the broader landscape" (Kruger, 2012, p. 17).

Shame alienates the self both from itself as well as from other people (Kaufman, 1996). Morrison (2008) held that shame is the most painful of all dysphoric affects, reflecting our harshest judgements about ourselves. South African author Jonny Steinberg (2008, p. 293) wrote that at the roots of shame "lie myriad watching, judging eyes that look at one and see a disgusting … figure". Here, the introduction of shame is constellated in relation to another who sees and judges us critically in our most vulnerable state. This critical judgement is then internalised and carried with one, so one can experience shame when alone too. Shame makes us feel that we are so far from being lovable, acceptable, connected, and happily and safely attached as we can imagine it possible to be. It can often be accompanied by the cringing that was described by Darwin, a need to hide from the (internalised) antagonist stare of the 'Other', and results in a bitter self-condemnation (Darwin, 1872), and can lead to what Leder (1990) aptly called "social dys-appearance" (Leder, 1990, p. 96).

7.2.4 Managing shame

The compounding of shame which happens to a person when their shame is recognised or exposed by another makes it very difficult to discuss or display one's shame. This results in a person often hiding it and remaining silent about it.

7.2.4.1 The need to hide or run away from shame

Interestingly, the roots of the word shame are thought to derive from the Middle and Old English word *sceamu*, meaning "to cover" — as in covering oneself, literally or figuratively (Lewis, 1971). This probably came from the Indo-European root *skam*, meaning to hide or cover, which shares the root with the following words: skin, camera and chamber (English); and *scham* and *schande* (German) (Lewis, 1971).

Kruger (2012), a South African psychologist, described her trainee psychologist students' response to shame in their difficult work: wanting to "leave it behind" and the "desire to run away" (p. 191) because facing the shame felt so unbearable:

> I myself often feel like fleeing, and so do many of my other students. Sometimes our flight is literal: going home early on particular days or leaving community work altogether. Others flee emotionally, using all kinds of sophisticated defence mechanisms. (Kruger, 2012, p. 191)

Shame has also been called the "Cinderella of unpleasant emotions" (Rycroft, 1972, p. 152, in Pattison, 2000), as to experience shame is to withdraw from all connection and be rendered voiceless and disguised — as if one ceases to even exist — resulting in social 'dys-appearance'.

7.2.4.2 Disguising shame

Shame is so difficult to tolerate that we tend to avoid naming and acknowledging it. This namelessness leads to either denial that it even exists in certain situations, calling it instead by the name of a more socially sanctioned emotion such as guilt, embarrassment, aggression, anxiety, hurt, insult or rage. The words "fear" and "anxiety" may also be used more broadly to disguise or hide shame. Ways to mask the common occurrence of shame in order to make it more socially acceptable are using terms such as "fearing rejection" or having "social anxiety", as shame pertains to unacceptability and social exclusion — being cast asunder and adrift.

Shame is also often disguised under a variety of defence mechanisms, such as contempt, envy, or grandiosity (Morrison, 2008). The shameful pain of rejection is also masked by anger or withdrawal, isolation of the self, and silence. Similarly, pride can be used to mask an inner sense of shameful unworthiness.

Despite the concepts of stigma and indignity hiding shame within them, Scheff (2011) maintained that researchers have neglected to explore this aspect of shame but instead have focused on the cognitive and behavioural aspects of these concepts.

Shame is also hidden in the way the English language makes apology by saying "sorry" only, not owning up to the shame one feels. Admitting that one feels ashamed of one's behaviour is far more powerful (Scheff, 2011); however, confessing shame risks the possibility of ostracism and being seen to be flawed, so the path of least resistance is usually followed.

7.2.4.3 Shame and guilt

Early psychoanalytic writers emphasised the affect of guilt representing internal conflict between the ego and superego, whereas shame was understood as a reaction to environmental disapproval and at that time carried little weight compared to guilt (Morrison, 2008). Freud theorised that guilt is based on the internalisation of social values, as opposed to shame, which is based on external disapproval or deprival by others about one's expressed needs and is therefore experienced earlier (Woodward, 2000). This view was modified by subsequent psychoanalysts who held that shame results from a conflict between ego and ego ideal (Piers & Singer, 1953), that shame is a result of the failure of the establishment of the ego ideal (Morrison, 2008) and, because it involves the entire self, is a narcissistic response of not living up to the ego ideal.

Shame and guilt are similar insofar as both cause distress and lower self-esteem. Both can act as guides towards "appropriate" socially sanctioned behaviours, and both can also trigger self-harm and suicide (Akhtar, 2016, p. 99).

Akhtar (2016) proposes the following differences between shame and guilt: shame is visual while guilt is auditory; shame stems from conflicts relating to exhibitionism whereas guilt stems from conflicts related to transgression; shame focuses on the self, whereas guilt focuses on the other; shame has physiological characteristics whereas guilt does not; shame results from failing to live up to an ideal image, whereas guilt emerges from disobeying real or imagined authority; shame is a consequence of tension between ego and ego ideal, whereas guilt is seen to be the result of tension between the ego and superego (from a psychoanalytic perspective); shame arises developmentally earlier than guilt; shame needs to be hidden, whereas guilt requires confession; psychological defences against shame include narcissistic self-inflation, social withdrawal and shaming

of others, whereas the defences against guilt include blaming others, fearing punishment, and masochistic self-harm (Akhtar, 2016).

Typically, social emotions such as shame and guilt are aroused in situations where a person's behaviour or traits are considered to be at odds with social mores. These self-conscious emotions are considered to be secondary emotional experiences that need evaluation of the impact of the mores of the social context and their impact on the self. As such, they are thought to impact on the management of moral decisions and actions (Tangney et al., 1996; Tracey & Robins, 2007).

Studies have compared and contrasted several of the self-conscious emotions by looking at their antecedent evaluations and the behaviours that were triggered (Tangney et al., 1996; Wicker et al., 1985). According to Baumeister et al. (1994), guilt should be understood as an essentially social phenomenon that happens between people as much as it happens inside them. Guilt appears to arise from interpersonal transactions (including transgressions and injustices) and to vary significantly with the interpersonal context (Baumeister et al., 1994) — for this reason it is easy to see how close it is to shame.

Shame and guilt can both be felt after a moral line has been crossed: guilt is elicited when one evaluates specifically what was transgressed ("I did a bad thing"), such as when one has damaged a significant relationship, and this generally influences the making of amends (Baumeister et al., 1994; Schmader & Lickel, 2006; Tangney et al., 1996), while shame has a more personal and structural aspect, located in the self, in which people attend to negative judgements about the self ("I was a bad person") and has been connected to motivations intended to escape the blameworthy event or hide from public view (Lickel et al., 2014; Tangney et al., 1996). One wants to run and hide when one feels shame; the difficulty is that what one wants to hide from is the judging, internalised 'other' within oneself.

It is easier to bear that one enacted a bad or hurtful behaviour than bear that one's very self is bad. As such, it is easy and more socially and personally convenient for shame to segue into guilt, the perceived lesser of the evils, especially as both of them are almost invariably paired together and differentiated each from the other.

As an aside, upon googling 'shame, addiction' to see what would emerge, I was intrigued that many authors link shame to guilt — even in addiction research the segue from shame

to guilt is happening. This fits with what Kakar (in Shah, 2016, p. 666) referred to as "psychological colonization" when describing the hierarchy between shame and guilt, perhaps highlighting the discomfort of having to engage with and bear shame.

7.2.4.4 Shame and anger

Shame can also hide beneath anger and use the emotional impetus (perhaps of needing to run away) to become angry — even enraged — in an attempt to push others away and therefore hide the shame that one is feeling. Anger is a more accessible emotion than shame, but it is often secondary to the underlying shame which has been triggered by a hurtful experience. Scheff (1997, p. 12) calls shame the "master emotion", arguing that the dominant component of hurt that leads to hatred and aggression is hidden shame. As a rule, one feels more powerful being angry — and, particularly, being enraged — than being ashamed.

Drawing on an extensive body of work on shame, ranging from philosophy and psychoanalysis to history and sociology, Scheff and Retzinger (1991) show that unacknowledged shame leads to anger and often rage. They argue that if shame is not understood and acknowledged, it results in aggression. In a clinical context, Retzinger watched arguing couples and formulated her shame theory, in which one hurt partner shames the other, who reciprocates by shaming the first offender (Retzinger, 1991).

Anger is a more grounding, mobilising and socially legitimate emotion than shame, which is possibly why it is used to cover shame. Toni Morrison (1970, pp. 48–49) writes in *The bluest eye*: "Anger is better. There is a sense of being in anger. A reality and a presence." But the anger just as rapidly subsides, and shame again takes its place.

Woodward (2000) provided an example of how shame hides beneath other emotions by using Virginia Woolf's *A room of one's own,* where the protagonist experiences intense shame when she reads the sexist writings of her male professor: "My heart had leapt. My cheeks had burnt." Woodward suggests that shame emerges first, followed by confusion, which is rapidly succeeded by anger. In Woodward's account of Woolf's description, the aetiology of anger is shame. Woodward (2000, p. 215) explains Woolf's description of anger as "the boiling point of shame".

Psychoanalyst Michael Lewis observes that shame disrupts ongoing activity, resulting in an inability to think clearly or to act clearly (Woodward, 2000). It seems that at this point, anger rushes in to give direction to the confusion through aggressive action. Shame is temporarily hidden in the powerful emotional surge.

Woodward (2000) accounts for the reparation of anger and shame in Woolf through an analysis of anger and, by implication, an analysis of shame, which leads to insight, acknowledgment and new knowledge. For Woodward, it is critical that both shame and anger be expressed and acknowledged. For Woodward, anger serves the function of appropriate self-defence and of retaliation. Anger is burned away, in the process, leaving the possibility of the power of reflection in its wake. Woodward refers to Woolf's character, describing her counterattack: she "began drawing cart-wheels and circles over [a drawing of] the professor's face 'til he looked like a burning bush or a flaming comet — anyhow, an apparition without human semblance or significance" (Woolf, 2005, p. 583). The protagonist in this vignette crushed the professor as he had crushed her. Seen here is a primitive quest for revenge and need to make others experience being destroyed just as they have destroyed us.

The understanding of shame that has been developed in this section will be used as a backdrop in the following section, where findings of the study are presented and discussed.

7.3 HEALING SHAME

"Why are you drinking?" demanded the little prince.
"So that I may forget," replied the tippler.
"Forget what?" inquired the little prince, who was already sorry for him.
"Forget that I am ashamed," the tippler confessed, hanging his head.
"Ashamed of what?" insisted the little prince, who wanted to help him.
"Ashamed of drinking!"
— Antoine de Saint-Exupéry, ***The Little Prince***

The tippler's story tells the story of the addict's cycle of shame. The need to address shame lies at the heart of the healing of addiction, as it is a quest to uncover what is hidden

and accept that which has been rejected. Part of this journey is about answering questions of identity and meaning specific to, and different for, each person. In addition, it is here in the mercurial context of shame that the addiction recovery group does its work.

This section looks at the many challenges involved in working with shame, beginning generally and then focusing on the experience of addicts participating in this study in their addiction recovery group. The section begins with a discussion on discharging shame, then goes on to look at the dismantling of shame and guilt in the context of the cycle of addiction. It then discusses what motivates addicts to move out of the addiction cycle, examining the roles of both shame and guilt in motivating self-change. The role of apology in the context of shame is addressed. Fear of the shame of disclosure to others is unpacked, looking at the risks involved and, finally, the healing of shame through witnessing the shame of others compassionately in the group is examined.

7.3.1 Discharging shame

Weingarten (2003, p. 51) captured the particular challenge of discharging shame: "Shame is often the hardest feeling to bear for many reasons, one of which is that there is no obvious way to express it. If we are sad, we can cry; if we are angry, we can yell, but how can you discharge shame?" Because of this difficulty, shame is typically managed by being 'acted out' (Kruger, 2012, p. 26) through behaviour which is often impulsive and anti-social, rather than by thinking or speaking about it. The intention of the 'acting out' is to rid the bearer of the difficult emotional state while also drawing attention to the behaviour and away from the shame.

The similarity between behaviour related to shame and addictive behaviour is apparent: the addict chooses not to feel the emotional discomfort and reaches for the substance or behaviour of choice instead. In the focus group, Bob described the self- and other-damaging nature of acting out before his recovery as follows:

> *I didn't like the person I was when I was drinking — my road rage was hectic. I was like a fuse waiting to go off.*

Gershen Kaufman, clinical psychologist and shame specialist, wrote about how shame signals a break in the "interpersonal bridge" that bonds people (Kaufman, 1992, p. 19). A

great deal of shame can result from the deceit, lies and betrayal committed by the addict in order to maintain her addiction. Potter-Efron (2002) explained that while an addict can consider other people to be unreliable and unpredictable sources of comfort, addictive substances, on the other hand, provide predictable and immediate sources of gratification; as a result, addictive substances and behaviours can increasingly replace human relationships in an addict's life and eventually become part of the addict's identity.

7.3.2 Dismantling shame and guilt in the cycle of addiction

It is critical for shame and guilt to be understood by an addict in order for her to dismantle it. An addict's continual focus on obtaining and using her substance of choice serves to distract the individual from her shame, as a means through which to direct her shame away from the core of her being. The consequences of the dereliction and destruction of authentic human relationships become irrelevant as the addict becomes consumed with her addictive experience, regardless of the price that is paid. Potter-Efron (2002) noted that if a person is suffering from shame, addictive behaviour will damage them further and recommends that therapy focus on drawing the attention of the addict to understanding her core shame issues.

In a focus group, one participant spoke about how special they felt using cocaine because it was a "classy, expensive drug" which enabled them to feel glamorous and worthy because of the attributes they attributed to it. The attributes of their substance of choice thus compensated for the shame and unworthiness they experienced.

Shame and guilt are understood to be both causes and consequences in addiction (Cook, 1988; Meehan et al., 1996; Potter & Hepburn, 2007; Potter-Efron, 2002). Patterns of addiction appear to be powerful inducers of both, although shame is dominant in the addiction literature (Meehan et al., 1996). For Fossum and Mason (1989, p. xiii), "addiction and shame are inseparable". Dealing with shame is vital for effective treatment of addictions (Gilliland et al., 2011). Distinguishing between guilt and shame is key to understanding the core sense of shame an addict experiences and its part in the addiction (Flanagan, 2013). A misunderstanding is assuming that the shame of the addict stems from guilt from a highly punitive superego and that once the addict has worked through the guilt, she will be released from the addiction (Flanagan, 2013). This assumes that if

the addict's sense of guilt is relieved, her need for a compulsive distraction will be relieved; this is typically not true of addicts, however. A release from guilt may, instead, have the opposite effect where the drives of the addict focus even more on the addiction and in this way increase her shame and the stronghold of the addiction (Adams & Robinson, 2001).

It is shame, and not guilt, that motivates the addictive cycle (Adams & Robinson, 2001). The looking for the substance of choice and then the rituals involved in imbibing or using it provide the desired distraction and escape from feelings of shame (Adams & Robinson, 2001). Shame is completely hidden at the highest point of the cycle and instead a false sense of self-esteem coupled with a compensatory omnipotence and grandiosity are experienced (Adams & Robinson, 2001). However, once the addict comes down from her state of euphoria and escape — often feeling physically unwell — the individual's feelings of shame re-emerge, compounded by the recall, or when others remind them, of their behaviour whilst intoxicated. This motivates a return to the addictive cycle in an attempt to escape. The vicious cycle of addiction and shame is thus reinforced, rather than weakened (Adams & Robinson, 2001). Bob captured this reality as follows:

> *Some of the stuff I remembered and some of the stuff I didn't remember and I was told about. And I thought, "Did I really do that?" And I didn't know where to put my head. So I would just start drinking again.*

7.3.3 Shame versus guilt as motivators of change

Ultimately, however, it is the shame from which the addict seeks to run away, and which results in the destructive addictive cycle, that motivates the addict to end the cycle and attempt recovery from addiction. In a focus group, McKenzie explained this as follows:

> *I didn't really think I had a problem. And then one of the psychologists really brought it home to me. And when I was in rehab, I thought about all the shame and humiliation and all the trouble I caused, I realised, "No, I don't want to do that anymore: waking up the next morning, not knowing what I did the night before. No, I don't want to go back to that."*

The longing for self-transformation — implying a total and structural change rather than the performing of different behaviour — has been found to stem from the discrepancy between the addict's current self (using) and her desired self (recovered) (Higgins, 1987). Another illustration of this was provided by Bob:

> *I don't like the person I am when I am drinking: I find him appalling. Disrespect and the language and treatment of women: I'm completely against it. But sometimes, when I was drinking, some of the things that would come out of my mouth, other people would hear them and they'd get upset as there would be ladies there. And the next morning, when I got told "you said this" and "you said that" I thought, "No, no: that's not me." And I don't want to be like that.*

Shame has been found to be a more reliable predictor of the motivation required for self-change than any other of the self-conscious emotions — including guilt (Tangney et al., 1996; Tangney et al., 1998). Tangney et al. (1996, p. 1267) hypothesised that withdrawal provoked by shame might be functional for the "necessary soul searching and re-evaluation of values and standards for conduct" after a "serious malfeasance" and provide the addict with a means to begin working on changing himself.

For these reasons, it can be seen that shame rather than guilt can more reliably predict the motivation for self-change — as opposed to embarking on a new set of behaviours of making amends — and can bring about the necessary internal reflection that is part of embarking on recovery from addiction.

Lickel et al. (2014) reported two studies examining the role of emotions, specifically shame, and their links in terms of the motivation of a longing for personal change. The first study found that upon recollecting experiences that involved shame, guilt or embarrassment, those that involved shame — then, to a lesser degree, guilt — were stronger motivators for self-change. The second study examined the effect of shame, guilt and regret over past events and discovered that the experience of shame was the strongest predictor in wanting self-change, despite high reported guilt and regret. Regret prompted self-reflection and a learning opportunity for the future but little desire to make amends and transform the self. In other words, shame was seen to be the greatest predictor in motivating self-change, arguably because of how difficult it is to bear. Such comparisons allowed the researchers to exclude the possibility that other self-focused, negative

emotions, such as embarrassment — which is a close correlate of shame — motivated the desire for self-change (Lickel et al., 2014).

This, of course, leads to the question of why, if shame promotes a desire for self-change, it sometimes triggers relapse (Tangney et al., 1996). One suggestion is that in addition to motivating a desire for change, shame may simultaneously elicit a motivation to block and avoid this difficult emotion and situations where it has been elicited. People have been found to report shame as their most unwanted emotion (Izard et al., 2000; Lindsay-Hartz et al., 1995). Shame can therefore be considered a double-edged sword: it may promote the desire for self-change while also evoking responses to avoid both emotions and situations that are counter to the intention to change. As a result, the motivation to change does not lead to actual change because the addict blocks her emotional response. This indicates that any intervention with an addict needs to be carefully titrated, because triggering too much shame can lead to relapse, which is characteristic of addiction, and yet too little discounts any possible motivation. Working with shame is a sensitive, skilful and delicate process — yet it is vital for recovery.

Stephen, one of the addiction counsellors, described the relationship of shame to relapse in his interview:

> *The main thing is to make them* [group participants] *realise that there is nothing to be ashamed of, it's not a failure and that they are not doing their recovery properly. … The idea is to not make them feel ashamed or less than, but to congratulate them that they have come back, to support them and to try and get them to see what they think they might have done differently, what did they not pick up — that awareness: what did they not see? What were they not aware of? And if they can start recognising that, they will learn and become more aware in future. But the main thing is not to feel a failure, not feeling ashamed.*

7.3.4 Guilt and apology

Making amends is a critical component of the twelve-step pedagogy. Apology is considered to be a necessary part of the process of repairing a damaged relationship and is critical to the health of the interpersonal bond. When guilt is acknowledged for

transgressions or omissions that have harmed the other, the guilty party is portraying themselves as having done something harmful. People are often ashamed of being ashamed, and defend against that by feeling guilt for their shame (Akhtar, 2016, p. 140). For Shah (2016), an apology can indicate that one is carrying shame and feels somehow inferior to the other. Once we face this, and address any shortcomings, as well as, if needed, give up the notion of being perfect, we are able to apologise, take responsibility and repair the harm caused by our hand. This addresses guilt. The process of taking responsibility in this way was illustrated by Mervyn:

> *You need to go out there and tell the people that you let them down or caused a problem for them, and to apologise. You need to explain to them that the reason you did that was because of being an alcoholic. They are not going to believe you: you are going to need to convince them. In order to convince them, you are going to have to be sincere and once you start being sincere to the person that you have done harm to then slowly, not overnight — because it's not an overnight process — they see Mervyn has now changed. He is keeping up to his word, his promises and he is trying to make a new life. And they will automatically make a decision on their own as to whether they can actually trust you, or not. The important word here is that you have to go there and be very convincing — in a nice way — and explain to them that all the nasty deeds that you did was when you were under the influence. But they are not going to believe you straight away. It's very hard work for you to get back the respect, the trust, from other people. In a nutshell, you have to prove not only to that person, but to yourself, that you are changed.*

Owning and understanding one's sources and experiences of shame are more complex, as the following section describes.

7.3.5 Fear of the disclosure of shame

Changing the self and the way one lives and manages one's shame requires courage on the part of the addict. Lansky (1995) and Retzinger (1991) found that survivors of physical, sexual or verbal abuse commonly experience intense shame (Lansky, 1995; Retzinger, 1991). Many addicts have experienced some form of abuse in the past. Several of the participants in the study spoke about how alcohol had helped them cope with or

avoid trauma in the form of domestic abuse and violence by numbing them emotionally or helping them to sleep.

Mervyn shares how drinking moderated his experience of the violent context he was expected to work in as a young policeman:

> *Initially, [drinking] was a social thing. Then, when I was posted to the Riot Unit, I witnessed traumatic incidents at that time — people getting shot, necklaced. And when you got home, you needed something to help you calm down. Because I was still young — I was twenty years of age. And you'll have a few drinks — not serious drinking — a few beers or ciders. But it escalated from the beers and ciders into harder alcohol as the years went by.*

Mervyn continued:

> *As you know, alcohol is mind-altering. It helped you to sleep. If you consumed alcohol, then you could go to bed and sleep, not thinking about the day's activities. The reason to consume alcohol at that stage was more to have a relaxed sleep, not realising that the thoughts and impressions of the previous day were still there. There was lots of violence. We were dispatched to various locations, we would sleep in tents in the violent areas, and at night, it's a different surrounding, you're scared, you're vulnerable and you also need to get your rest and sleep and the only way you found comfort was in a bottle of alcohol, whereby you'd have a few drinks and go and sleep. Then you'd find when you're sleeping in a tent, that the cold doesn't worry you. Nothing else worries you; you just fall off to sleep.*

Applying the concept of trauma loosely here, Herman (1992, p. 1) described "the conflict between the will to deny horrible events and the will to proclaim them aloud" as being "the central dialectic of psychological trauma". She states: "When the truth is finally recognised, survivors can begin their recovery" (Herman, 1992, p. 1). However, shame tends to lead to silence because of the fear that if you do speak about your shame or about what you are ashamed of, you risk being shamed again. As a result, it is "the very nature of shame to stifle its own discourse" (Wicomb, 1998, in Charos, 2009, p. 273). While shame must be spoken in order to heal the bearer, it is so difficult to talk about that the very language used to speak about it is often mediated by the desire to conceal it (Charos, 2009).

7.3.6 Healing shame through an addiction recovery group

So how can participation in an addiction recovery group assist with the healing of shame? Khantzian (2003) considers an addiction to represent, in some cases, an attempt to self-medicate painful or confusing emotions or an overarching problem in self-regulation. Ultimately, the work of recovery involves "re-building the self, regulating emotions, tolerating distress and establishing healthier relationships" (Weegman, 2017, p. 294). With this in mind, we can focus on understanding how a recovery group can help an addict to explore the link between shame and their addiction, and learn to heal their shame through relationship.

According to Adams and Robinson (2001), a group intervention can facilitate a more thorough working through of shame than individual treatment. A group encounter creates a supportive and safe environment conducive to the dismantling of shame and the reorganisation of the cognitions that have stabilised shame in the psyche. In a group, the participant is given permission to open to and depend on others, and to feel their feelings and needs; this is a key to experiencing release from shame (Adams & Robinson, 2001).

Spero related his experience of how the support of the group created a space where he could begin to release shame:

> *I had so much support* [in the group] *against the massive feeling of shame and guilt: shame of my addiction. The group spoke about shame and guilt and self-centredness and making amends and I could relate to it. Every week … I used to cry. Emotions would just pour out of me and I knew that was a good thing.*

This reveals that sharing the human experience of shame, making the implicit explicit in a named and titrated way, becomes a key part of the process that heightens the probability of "moving forward" (Wallin, 2007, p. 261, in Kruger, 2012, p. 27), where one is not mired in shame.

In the group, the common feelings that were shared bonded participants to one another, and participants saw shame in each other while remaining connected. "Paradoxically," Swartz states, "it is the resonance of shame that crafts the way forward ... a shared experience of shame provides the vehicle (Swartz, 2012, p. 207). The challenge is to learn

to live with the feelings and not disconnect from ourselves and each other. Spero expressed how membership in the group provided a way out of his isolation from others:

> *I need the group to help me manage my isolation. From week to week I am isolated. No one lives life like I do. … And for me to come into a group where I can just* [breathes out and throws down arms] *chill — chill and hear other people's struggle — it makes me feel a part of humanity. … So I come to the group to stay connected to people and to feel normal.*

The origins, as well as the redemption and healing, of shame in the self occur through relationship. Shame does not have to shut us up or shut us out. In the recovery group, those bound by both addiction and shame sit in a circle of mutual acceptance, commitment to and struggle for sobriety. If shame is recognised, and the reasons for the shame spoken, there is potential for connection (Kruger, 2012; Teicholz, 2006; Wallin, 2007). Attention is paid to the shame that is unspoken, yet present (Beebe et al., 2005; Beebe & Lachmann, 2002; Bollas, 1987; Fonagy & Target, 1999; Fosshage, 2005; Lyons-Ruth et al., 1998). Shame can be made explicit by acknowledging, speaking about, and witnessing it, and healing can occur (Bruschweiler-Stern et al., 2002). That all participants are bearers of shame creates a binding empathy — perhaps it is the shared bearing of shame, not only the commonality of addiction — that binds the group participants. The shame may be too great for some group members to speak of; instead, being in the presence of someone else who is speaking, and bearing witness to their experience, invites them into the group process. In his individual interview, Bob reflected on this:

> *In the beginning I did hold back with the abusive relationship and listen. But now, no: I am open and honest about everything. I was a bit embarrassed to share about it* [shame]. *I realise that other people could be in the same situation as me, so I realise that it's not just me that's had it happen to him.*

Oliver (2001) wrote that survivors of the holocaust, rape and slavery have reported feeling the shame of both the experience of shame and of bearing witness to it. Addicts in a recovery group can, similarly, feel both their own shame and the shame of the others. This is particularly apt, as much of the destruction and loss is of their own doing.

> *When people share their tragedies of how much they have lost, it's gut wrenching. … I should be glad of the pain as it is making me into a different person. — Spero*

For Oliver (2001), shame comes from being seen as a mere object. Even in a situation where one has no option or power to resist abuse, the experience of becoming an object to another can induce feelings of shame. The addict can be seen to repeat this objectification by objectifying herself, suppressing and subverting all of her needs through addiction to a substance. The destruction of the self of the addict and the objectification that occurs was demonstrated in the focus group by Bob:

> *And waking up and not remembering what happened the night before and what I had done, and [to] be ashamed and humiliated: there's no word for it — for how I used to wake up. I don't know why I did it — the vicious circle — wake up humiliated and ashamed and the next night: just go out and do the same thing — over and over and over again.*

Kinston (1983) explains that object narcissism derives from early experiences of the child attempting to elicit love from parents by being who they believe the parents want them to be at the cost of the authentic self-expression of the child. Over time, that authentic person becomes lost under an assumed identity of pleasing others and the existential questions facing the individual which speak to identity and meaning in life — such as "Who am I? What do I think? What do I want?" are not addressed. Shame causes the child to focus on others' needs at the expense of his own (Kinston, 1983).

A key feature of adult development is the balancing of the ongoing integration of one's own identity with intimate relationships and participation in a wider social world. In the addiction recovery group, participants engaged in the exploration of their identities, their uniqueness and their meaning while learning how to care for their newly emerging sense of self and awakening needs. They learned how to attend to their suppressed feelings and needs — which they may experience as being 'selfish' — rather than to exist merely as an object or to perform a function for others. Through members of the group legitimising and encouraging each other to prioritise their own needs, and witnessing each other's experience, each member became empowered.

> *When I hear other people's stories, I think, "Hey, I was like that as well!" Now I'm not like that anymore. I can see the changes in myself. When listening to what people did when they were drinking, I realise that I used to do that as well. I don't do that anymore. It's totally different. — Bob*

For Oliver (2001), the act of witnessing can help restore self-respect and a sense of self as an agent in the roles of both speaker and witness. It is the very act of responding compassionately to another that heals both. The role of witness provides a participant the space to listen caringly and with interest to the narrative of another; with the focus not directly on oneself, one can recall one's own experience of being objectified and shamed. Bearing witness to another's narrative of shame allows one to reconnect compassionately with oneself in the compassionate acceptance — free of expectations — of the group dynamic.

> *It makes you think of the days when you were here — remember what you were going through. You sympathise with them and it keeps you going: it keeps you strong; sharp. — Mervyn*

Addicts come to the group as objects — disconnected, focused largely on their substance of choice, struggling to free themselves from the domination of their addictions. It is through both listening to others as well as speaking and giving voice to their experience and emotions that participants are able to claim back their own subjectivity as well as give others the opportunity to do the same. The right or ability to speak is accorded to each recovery group participant along with the rights and respect afforded each member, as well as being accorded a place and time to speak according to the group guidelines (discussed in Chapter 8). This allows the addict to begin the work of recovery from addiction and, ultimately, identity transformation.

Oliver (2001) proposed that the experience of bearing witness in the context of a caring connection between participants encourages us to become closer to others and "opens up the possibility of working through rather than merely repeating the blind spots of domination. The loving eye is a critical eye in the sense that it is necessary and crucial that these testimonies should be remembered, why, and in what way" (Oliver, 2001, p. 75). She says that "witnessing is the heart of the circulation of energy that connects us, and obligates us, to each other" (Oliver, 2004, p. 202). This was alluded to by Karen:

> *We all want the same thing — to have a safe environment, to feel that we actually matter when you come to group and to know that people respect your opinions and you as a person. Nobody will ever leave here and say "Oh, that was a waste*

> *of time." It will never be a waste of time because you don't know whose life you have touched.*

Bearing witness to each other's narratives allows these experiences to be remembered and carried into daily life, where they serve to strengthen each listener's resistance to cravings and temptations. Having had others bear witness to one's vulnerability and shame also helps to strengthen the resolve of the one who has shared to resist relapse. As stated by Bob:

> *To see how other people coped: what they did. Listening to everybody else's stories … gave me courage that I could do it too.*

Furthermore, through witnessing, one acts to promote the practice of making connections — through intimacy, kindness, and compassion (Zembylas, 2006, pp. 321–322). For Oliver (2004), the process of witnessing is about accepting the other as a human subject and not seeing (and judging) them as an object. Deepening the connection with others entails the opening of oneself and letting the other enter one's heart: the opposite of the experience of shame.

Referring to learning from others, Mervyn related how the inpatients in the recovery group — who were new to recovery — reminded him of where he had come from and where he could end up, and increased his sensitivity to himself and others through having experienced early recovery personally. The movement between his conception of himself and the other as subject and object is interesting here:

> *My motivation comes from the inpatients, because when I see one suffering — holding his stomach, all gaga'd — you see what the inpatients are going through and that is an eye-opener as to what is going to happen to you if you relapse. You gonna come back looking like them. And I don't want to do that — because they are suffering. I suffered through my initial stages of recovery and I do not want to go back … by looking at the inpatients it strengthens me. It takes me back to my basics.*

Adelman (2016, p. 201) provided a powerful example of seeing the other as a subject in the following description of an encounter with one of her psychoanalytic patients:

> Sitting with Laetitia, I recognised in that flash of memory that, with this patient, an old reservoir of shame had opened up in my mind. … As though a curtain had lifted from in front of my eyes, I suddenly saw Laetitia in a new light. My irritation dropped away from me, and in its place, I felt deep compassion for the suffering she had endured and the scars she could not hope to erase. (p. 201)

Adelman (2016) goes on to explain how, through their relationship, Laetitia was finally able to see herself as an integrated whole person.

This happens also in the sacredness of the group when masks are dropped and eyes can finally see each other and themselves as whole and accepted. Spero described this experience:

> *Not being judged is big-time important. And for me to admit I am an addict, even to new people: that is very freeing for me. The more I confess my shame, the more freeing it is for me.*

Spero provides a beautiful example of the transformative practice of witnessing, which allowed him a freedom to launch into new ways of being, and a self and life worth living. Addicts are no longer condemned to the endless cycle of shame and addiction but are released by each other. Similarly, Zembylas (2006), referring to Paulo Freire's work, describes essential elements of witnessing as including critical knowledge about the world and also the courage to love and find faith in the people, since it is to them that witness is made, and ultimately, then, resonating with Oliver (2001), to find love and faith, at last, in and for oneself. Bob emphasised the courage that witnessing and identifying with another person's struggles provides:

> *I've grown. ... I can see there's a lot of people here going through the same struggles that I am, and if they can do it, so can I. It gives me courage. I'm not alone. If I see people going through something worse than me and if they can do it, it makes me think that I can do it too.*

While shame may be an inescapable aspect of life, it can also be ameliorated (Moore, in Akhtar, 2016, p. 45); hope lies in the individual's capacity to relate to themselves in a human, compassionate, un-shaming way throughout their lives. Healing begins with opening oneself and being seen by the eye of the other — once the cause of shame —

now, through connection, redeemed. Through witnessing the humanity of the other, one finds, at last, a connection within oneself and with a greater humanity — the belonging which is, ultimately, one's birthright as a human.

7.4 CONCLUSION

The journey through shame begins and ends in relationship. This chapter has explored the aetiology and workings of this complex, bedrock emotion, providing a nuanced account of the role of shame in addiction and how it is dismantled through various processes in the recovery group.

The role of anger in managing shame has been discussed in this chapter; its relationship to addiction and how the recovery group functions in terms of working with anger to support the recovery of its participants will be explored in the following chapter.

CHAPTER 8
PSYCHOLOGICAL MECHANISMS: THE ROLE OF ANGER IN ADDICTION AND RECOVERY

In analysing the findings on spirituality and religion, and the dismantling and reworking of shame in the recovery group, the previous two chapters have examined the importance of emotional regulation in addiction recovery. Another key emotional aspect that emerged in the findings was anger as a trigger of relapse. Thus, being able to understand and manage anger differently is critical to recovery. As with the previous chapter, this chapter, locates anger in the literature findings and then highlights the specific findings of this study that relate to how the addiction recovery group worked with and managed anger. In this way the group mechanisms are shown.

8.1 INTRODUCTION

Anger is considered to be an emotion that "remains one of the most significant problems facing our society today. In a world growing more crowded, with the pace of life increasing exponentially … there is a growing potential for anger to play a destructive role on a frighteningly large scale" (Mayne & Ambrose, 1999, p. 362). Anger, and the challenge of controlling and managing it, are increasingly common reasons that people seek therapy, globally; it is not surprising to find anger well represented in the addiction population (DiGiuseppe & Tafrate, 2003).

8.2 UNDERSTANDING ANGER

Anger is an intense emotional response to a perceived provocation, which is experienced commonly and universally by human beings (Videbeck, 2006). Anger often arises if one's personal boundaries (emotional or physical) have been violated: a personal line has been transgressed. Psychotherapist Michael Graham (2014) viewed anger in terms of one's expectations and assumptions as to how the world should be, explaining that anger is most often triggered when our experience of how the world really is does not match our expectations. This was echoed by Hareli and Weiner (2002, p. 188), who viewed anger

as “an accusation or a value judgment that another person could and should have done otherwise”. This assertion implies that angry individuals believe control over solutions to their problem lie outside of themselves and with the other person — the transgressor — whom they believe could have and should have acted differently (this is termed an external locus of control).

The notion of controllability implies power over the other. Unpacking this idea further suggests that the angry person believes that the transgressor holds power over them. From an anger management perspective, it also suggests, then, that if individuals believe they have control over the solutions to their problems, they may feel more empowered to act and may be less likely to become frustrated and angry. In South Africa we have a “culture of violence” based on a historical suppression and oppression of feelings and aggression (Masango, 2004).

Studies have shown that feelings of powerlessness are triggers in the formation of anger and aggression (Farrow, 1989; Thomas, 1995). This fits with therapeutic work on attribution, locus of control, self-esteem and identity to remediate these (Kassinove & Tafratem, 2002; Mayne & Ambrose, 1999; Mohr et al., 2007; Okuda et al., 2015; Reilly & Shopshire, 2000). Arguably, one can also feel anger towards oneself and one’s own responses in anger-inducing situations (Williams, 2017). Understanding this and taking responsibility is therefore the beginning of this work.

Lacan (1977) saw anger as a psychological defence, functioning to protect the psyche against threats of fragmentation. Anger is an effective way to keep others away and thus functions as a crude mechanism to protect the psyche from external threat. In this view, underneath the anger lies a fragile self that knows no other way to respond under perceived attack.

Anger has also been described as a pressure cooker insofar as when it is met with increasing resistance, anger often eventually explodes (DeFoore, 1991). For Mohr et al. (2007), anger is considered to be a destructive emotion in that it impairs one’s ability to rationally process information and exert cognitive control over one’s behaviour. Often the result of this is that the person who acted in anger because they felt violated ends up causing additional harm to themselves through being misunderstood as result of their actions which have harmed others.

While anger is often correlated with aggression, anger is best understood as an emotion while aggression is a behaviour that is often motivated by anger. In psychodynamic terms, anger has an internal object whereas aggression has an external one. Aggressive acts may be directed at the self, at others, or at an external object (Glancy & Knott, 2002; Glancy & Saini, 2005). However, while anger can trigger aggression and increase its intensity, anger is not a precondition for aggression to occur: aggression can occur without anger (such as in war). These terms are often used interchangeably, however, which can cause confusion.

It must also be borne in mind that the expression of anger is tolerated socially to a certain extent: it does not incur a social judgement of weakness in the same way that shame, sadness or vulnerability might. However, anger is often a secondary emotion that has another emotion underneath it. According to Scheff and Retzinger (1997), the dominant component of hurt, when it leads to hatred and aggression, is hidden shame. They hold that anger is often a response to shame — an aspect which was explored in the previous chapter. Whatever its impetus, it is important to understand the place of anger in addiction and recovery, as discussed in the literature and explored by the participants in this study.

8.3 ANGER AND ADDICTION

Anger is crucial to address in addiction and recovery, as anger and aggressive behaviour occur more often among substance users than in the general population (Miczek, 1987; Murphy & O'Farrell, 1996; Temple et al., 2009). In a study of 4 995 new patients seeking addiction treatment, 40% reported anger problems at intake, while 19% reported acts of physical aggression linked to substance use. In the same population, 9.7% reported committing violent acts linked to substance use within the previous ninety days (Collins et al., 2005). A Swedish study found a 13.2-fold increase in the risk of criminal violence within 24 hours of alcohol consumption (Haggård-Grann et al., 2006).

A summary of 26 studies in 11 countries found, on average, that 61.5% of offenders drank alcohol at the time of committing violent crime (Murdoch & Ross, 1990). Brookoff et al. (1997) found that 92% of perpetrators of intimate partner violence (IPV) used alcohol or drugs on the day of the assault, and 72% had been arrested previously due to substance use. Substance use disorders are commonly found among clients presenting for anger

management and IPV treatment, with about 50% of the male abusers in the sample admitting to alcohol-related issues (Tolman & Bennett, 1990).

Research indicates that anger is a key emotion found in both the onset and the maintenance of addiction, as well as within the relational and psychological dynamics of relapse (Beeder & Millman, 1992; Daley & Marlatt, 1992; DeMoja & Spielberger, 1997; Gilbert et al., 1998; Larimer et al., 1999; Marlatt et al., 2012). This dovetails with the self-medication hypothesis that proposes that addicts use addictive substances in order to self-medicate and regulate emotions such as anger (Khantzian, 1997).

Researchers in the areas of anger and violence (Dutton, 1995, 2008; Greenberg & Paivio, 1997) and substance use (Khantzian, 1997, 2012; Khantzian et al., 1990) have stated that dysregulated emotion is a significant contributing factor to these phenomena. DeMoja and Spielberger (1997) found that drug users experienced anger more often than non-users, were less likely to feel in control of their anger, and were more likely to express anger towards others or to their surrounds. Kassinove and Tafratem (2002) found that study participants for whom anger was a strong trait tended to use alcohol and drugs when feeling angry, when compared with participants for whom anger was a weak trait.

The literature published by AA states that reduction of anger is critical to recovery (Zakrzewski & Hector, 2004). In fact, anger is the only emotion highlighted as a trigger for relapse: “Resentment is the number one offender. It destroys more alcoholics than anything else. ... If we were to live, we had to be free of anger” (AA, 2001, pp. 64–66). Consequently, an essential emphasis in the twelve-step programme documented in AA’s primary text is to reduce anger (AA, 2001), yet this proposed mechanism has been investigated very little despite anger appearing to be a serious, enduring problem related to relapse and heavy alcohol consumption (Kelly, Stout, Tonigan, et al., 2010). Results suggest that AA attendance alone may be insufficient to alleviate the suffering and alcohol-related risks specifically associated with anger (Kelly, Stout, Tonigan, et al., 2010).

Anger has been found to be a trigger for the use of cocaine for many cocaine addicts; it is thus likely that this population would be more likely to relapse following an anger episode than would other addicts who are better able to modulate their anger (Reilly & Shopshire, 2000). This lends hope to addiction recovery pedagogy that focuses on

emotional management — specifically, anger — as it points a way for the addict to gain control over relapses by learning new ways to manage anger.

8.4 REWORKING ANGER IN THE ADDICTION RECOVERY GROUP

This section focuses on links between anger and addiction in the recovery group, and explores different approaches to teaching and learning about anger and its management.

In the focus group, Stephen emphasised the broadly destructive nature of addiction to the self, highlighting how the positive, optimistic, fun and good parts of himself became eroded so that what remained was angry, bitter and cynical. He found alcohol more destructive to him personally than cocaine:

> *Cocaine did the most damage financially; but alcohol, personally. As it eats away at your self-confidence it makes you bitter and angry and, towards the end, drinking would bring out the bitterness, anger and resentment at other people who seemed to be coping with life and I couldn't. Then I would be a cynic and then look out for their inconsistencies and blatantly pick them out. I resented the ease with which people seemed to do things. I started to realise, but didn't do anything about it, that I had an addiction and was not wanted at parties anymore. They would like me if I was in a reasonable intoxicated state, but not if I was bitter and hurtful and spoiled their fun.*
>
> *At parties, people would disperse when I came up to them. I was unemployed and expecting people to buy me drinks and resent it if they didn't. What started out by having fun and brought out the appealing side of me brought out a nasty, angry side of me, which I didn't even realise and that it was growing and suppressing the appealing side. And I blamed everybody else. And I was not happy with everything I had and was.*

Here we see highlighted Hareli and Weiner's (2002, p. 188) view that anger is "an accusation or a value judgment that another person 'could and should' have done otherwise". An external locus of control is revealed in this quote by Stephen, where he resents and blames others for not buying him drinks and for their apparent ease in social situations. His jealousy emerges due to his low self-esteem, which leads to angry and

jealous feelings. The anger of the addict at everyone and everything is clearly illustrated here and plainly demonstrates the self-centred attitude of the addict and his belief that life should be a certain way; when it is not, he responds with anger — to which he feels entitled.

Speaking as an addiction counsellor, Stephen notes:

> *Addicts like to blame everybody else. Today in group we heard about the guy who is always having arguments with his wife. He needs to look at "what is my role?" and "can I change what I do? I can't change what she does, but can I change what I do?"*

Often addicts are admitted into psychiatric facilities for anger management and not addiction issues — although their admitting health care professional may be aware of the addiction and only able to convince the patient to admit themselves for anger issues, rather than addiction, due to the denial surrounding the addiction.

McKenzie shared the following story about making the connection between his alcoholism and anger as an inpatient, with earthy humour:

> *I stated to Dr X, here: I said, "I don't have a problem with alcohol, I have a problem with anger." And he said, "Yes, you do." I came here for anger. That was the only reason I came. I went to Dr X and he said, "How much are you drinking?" And I said "10 to 12 quarts," and he said, "A week?" And I laughed at him and said, "That's in a day." He said, "You've got an alcohol problem." I said, "I don't." He said, "You're using alcohol to escape from the anger and your anger is being fuelled by your consumption of alcohol. If you admit to having the problem with the alcohol, your problem with anger will subside." I said, "Nou praat jy 'n klomp kak"* [colloquial translation: now you're speaking a heap of shit] *but two days later I realised what he was saying, and it was true. Once they had established what the problem was — that the main cause was alcohol — they could slowly and surely fix the anger problem. The less you drink, the less angry you get. I still get angry — make no mistake, everyone feels anger — but I am more diplomatic about facing the challenges of my job.*

This is a clear example of Khantzian's (1990) self-medication hypothesis and the vicious cycle which self-medicating with intoxicating substances engenders.

8.5 GROUP PEDAGOGIC APPROACHES TO WORKING WITH ANGER IN ADDICTION RECOVERY

So, what pedagogic approaches do addiction counsellors use to facilitate addicts' development of a healthy response to feelings of anger rather than picking up the substance of choice?

8.5.1 Understanding the relationship between one's emotion and substance of choice

Firstly, according to Stephen, the addict should understand the relationship of their substance to the way they cope with life:

> *We use our substance of choice as a way of escape and as a coping mechanism to cope with life, our emotions, our inadequacies, and our shyness — whatever; our depression, our anger — whatever. So, if we take that away, what is our coping mechanism? So, we basically have to learn how to cope — learn new coping mechanisms. The addict's mind-set is to escape everything — responsibility, trouble, bad feelings, confrontation: there is a need to withdraw, to go away. We need to realise that it is possible to face those and to deal with them by learning how to face them and by taking responsibility, which will bring about the inner strength to carry on, building up our self-esteem. The more we escape the more we weaken our ability to cope: it's diminishing all the time.*

This complex insight is crucial to the addict's recovery. However, it is not just a cognitive insight that needs to be established in the brain of the recovering addict, where he understands the connection between his substance and his coping: he also needs to experience what he is coping with and the emotions of it — without resorting to the substance of choice, which is why being in rehab is so important — in order to find

different ways of managing these triggering emotions. The addict is required to take responsibility for himself and his emotions without acting out.

8.5.2 Linking the present feeling of anger with those one is really angry with

Dave, one of the counsellors in the recovery group, noted how these feelings emerged in the group, his pedagogy focusing very much on the physical aspects of the individual — body language and behaviour. Dave used the group to work with anger:

> *The other day we were talking about someone in group who was on their medication* [to come off their substance of choice] *and obviously loving the buzz and I could see the gentleman next to him was looking down. But down for me, in addiction, means that there is hidden anger there. And I asked the gentleman: "Why are you so angry? Who are you angry at?" And he said he wasn't angry, but I saw him clench his jaw and the muscle in his cheeks go and I knew straight away he was angry because he made that response. So, what it did was it opened up for him to say, "I'm angry with this person, and that person, and this other person." He wasn't angry really with the person next to him on the buzz: it triggered his own feelings.*

Here the counsellor used the here-and-now physical portrayal of emotion to connect the addict to those people in his life with whom he really was angry. The addict was then able, with help, to work through his anger with those people, strengthening his capacity to gain cognitive control over his anger when it triggered in the future using these insights, rather than defaulting to his substance of choice.

8.5.3 The cultivation of constant awareness

Stephen noted that recovery is far more than just cessation of use of the substance of choice: being in recovery requires constant vigilance and awareness:

> *Awareness — of everything: of your physical, mental, emotional, spiritual being. If I'm feeling hungry, or have flu, run down, it's going to affect my emotional side,*

my physical side, and my spiritual side — if you want to go into that. I am weaker overall and therefore my ability to deal with stress or life is diminished and I will be more ready to take a drink or drug because I am not strong, I am weaker. If I am feeling physically ill I need to address it, if I am not sleeping properly, I need to address it, if I have headaches, or feeling depressed or angry, or having arguments with people, I need to address it: look at why, and look at my role in all of this.

Here we see the change in locus of control from external to internal, where the addict now monitors himself and takes care of his own needs. This creates a sense of empowerment and capability within him which will reduce the trigger of helplessness that lies beneath so many experiences of anger. Being able to take more appropriate corrective measures to deal with situations, such as those suggested by Stephen, is likely to impact positively on the formation of frustration and anger. This correlates with Farrow (1989) and Thomas (1995). Being able to take responsibility and choose solutions, with a more confident means of dealing with emotions, enhances the well-being of the addict, who gains an increased sense of self-esteem as he is successful in these tasks.

8.5.4 Taking responsibility

The importance of taking responsibility by being more appropriately assertive was illustrated by Bob who, while still feeling anger, dealt with it differently with positive results:

I used to get very angry; my road rage was hectic. I was like a fuse waiting to go off. But since I have got divorced, I don't get angry, I don't get road rage anymore, I don't scream and shout at other drivers or taxis or anything like that. I'm a lot more calm.

Bob realised that during his marriage his anger had built up through the verbal and physical abuse he had experienced from his wife, and he had used road rage and excessive binge-drinking over weekends to vent it. Once he stopped drinking, he could think clearly about what he wanted from life; he ended his unhappy marriage and his anger dissipated.

Sharing his journey with the group who supported and validated his feelings allowed him to become aware of his feelings and what he really wanted from life.

8.5.5 "Playing the tape forward"

A technique that has helped Jashwin is called "playing the tape forward" where, instead of losing his temper, he now stops and thinks through what would happen were he to explode and lash out as he did formerly. He remembered the years he did this and where it ended up and this gave him pause to consider his actions:

> *If I'm going to lose my temper and get angry and scream and shout, then I'm going to bring all these ugly scenarios back. So, I ask myself if it's worth it and then I walk away. I can address it later when everybody is calm. And I practise it almost every day. I had that situation last night when my wife said something out of turn. I could feel the anger in me and that I was on the edge of losing it. So, I went and played with the dog, calmed down, and I didn't even see reason to discuss it with her because it was so petty.*

We can see that Jashwin's trigger was his belief that his wife should behave or speak in a particular way and that she "said something out of turn". However, what he did with his anger was critical. For Julia Cameron (1992), anger has a message that should be acted upon rather than reacted to and acted out.

8.5.6 Taking time to reflect before responding

For Mohr et al. (2007), the reflecting upon and speaking out of anger can mobilise psychological resources and boost determination towards the redress of grievances as well as the correction of destructive behaviours. He holds that this can also facilitate patience. Finding a new place for the triggering emotion of anger, by talking it through thoughtfully and being sensitively listened to by others, occurs in the addiction recovery group where there is an acceptance and understanding of the expression of such difficult emotions. Because a fair number of the group's participants were initially admitted for anger management issues and then discovered that they were addicts, there was a shared

camaraderie and bond over this, which facilitated those with anger being able to work through it in a safe way.

McKenzie showed how far he had come as follows:

> *I've become more rational about solving problems than I would have been when I was alcohol-dependent. Alcohol gives you Dutch courage and you just act on the spur of the moment. Being sober you think, "Hmm, let me chew this over, and swallow it, and digest and see — isn't there another angle?" If there is no other angle, I revert back to what I used to do but now I'm very reluctant to do that. Being in the environment I'm in — the police — you can't just moer* [translation: beat up] *people — as much as everybody says we do.*

Jashwin shared how he deals with anger now:

> *And even in my public life, there are certain battles that I choose. Those that are worth taking on, I take on, and those that are not worth taking on, I don't take on. I give myself time to think about things now. And, most importantly, I now know how to say no. I was the crap magnet for the community, which everybody knew: anything you need, just go to X. And now I say no. It's my time now. "I can't help you, I'm so sorry." And there's no "buts": it's just "no". And the happiest person for all of that is my wife. She has me back and I've started doing things at home — for example, I moved a mirror down that my wife waited three and a half years for me to do.*

Here it can be seen how both addicts in recovery have learned to live with greater awareness of various aspects of themselves — mental, physical and emotional.

8.5.7 Awareness of common relapse triggers

On the topic of living with global awareness and applying one's knowledge of addiction to one's self at a particular time, Mervyn said:

> *We need to be free of every mind-altering substance — even if not our substance of choice. ... Other things are important too: HALTBI triggers [hunger, anger,*

loneliness, tiredness, boredom and intensity of emotion]. You have to use it. If you're hungry sometimes, it does set you back a bit, it can trigger cravings. All of these things are triggers so we need to look at that as well. There are so many things that we have been taught that will come to the mind when the situation arises.

Here we can see that competency in self-care is emerging through application of new knowledge and understanding.

Taking the three comments above as exemplars of the reworking of anger, it can be seen that these participants have learnt to take time to think things through and to decide on the best course of action, rather than resorting to their substance of choice and lashing out in anger and thus continuing the vicious cycle of addiction and anger. In addition, they have learnt skills regarding assertiveness, playing the tape forward, prioritising self-care and taking responsibility for what is important to them in their lives. They speak with dignity and confidence, indicating a reliable sense of self that is more resilient and less vulnerable than during addiction, and we see a sense of self-esteem and a valuing of relationships.

8.6 CONCLUSION

In the findings of this study, the group itself emerged both as key to the reworking of anger and — as Woodward (2000, p. 215) elegantly summarised Woolf's description of anger as "the boiling point of shame" — the dismantling of shame, which was discussed in detail in Chapter 7. Given that the rate of those with anger issues is higher among addicts than the normal population (Okuda et al., 2015), this is an important emotion to examine. The application of various skills, knowledge and techniques learned through the group can enable an addict to work with her anger in a way that is both constructive and transformative in its contribution to both her emotional regulation and her self-management.

The next chapter focuses on the trait of honesty and how working with this in the group contributes significantly to the transformation of the recovering addict. This trait is profound in its impact within both addiction (in the form of dishonesty) and recovery.

CHAPTER 9
PSYCHOLOGICAL MECHANISMS: THE RECOVERY OF HONESTY

9.1 INTRODUCTION

The previous two chapters presented findings regarding two emotions that play a key role in addiction and recovery: shame and anger. The importance of the next finding, honesty, is explained in this chapter, by examining various components and aspects of its recovery. The chapter introduces the notion of integrity, situating it in the literature and underscoring its importance to the development of the self and as foundational to identity. Honesty, dishonesty and denial are explored in terms of the fragmentation of integrity to the sense of self that occurs in addiction and is gradually restored through participation in the recovery group. Dishonesty is damaging to both the addict and those around her, and hence the recovery of honesty is essential. The development of the consistency of self will begin to be explored in this chapter and then continued in the following chapters examining empathy and mentalisation, and self-esteem and self-worth.

9.2 UNDERSTANDING HONESTY

9.2.1 Integrity

According to the Random House dictionary, honesty is "truthfulness, sincerity, or frankness; freedom from deceit or fraud" (Margolis, 1998, p. 98). Integrity is "adherence to moral and ethical principles; soundness of moral character" (dictionary.com). Honesty is able to exist without integrity; however, integrity is unable to exist without honesty. Integrity has been considered to have a moral aspect. Being a good person implies living with honesty. Plato and Aristotle developed the theory of virtue ethics, focusing on questions like "how should I live?" and "what comprises a good life?" which involve the application of integrity and honesty. These are issues addressed in addiction recovery.

Integrity refers to the wholeness, or unity, of the self, grounded in an inner consistency between deed and principle. The world "integrity" shares etymology with other words related to unity — "integer", "integral", "integrate", "integration" — which derive from

the Latin *integrare* meaning "to make whole". A person is considered to have integrity if her conduct is congruent with her principles (Luban, 2003) — living true to an unwavering moral compass. Integrity is one of the human qualities that is most threatened by addiction: both the sense of wholeness (integration) of a person and their trustworthiness and dependability are lost as a person is absorbed increasingly in addiction.

Integrity is considered to be something one has control over. It is not an emotion but instead a quality or trait within a person that one can choose to develop or neglect, which, according to Nietzsche, "remains something in the becoming which we may either cultivate or restrain, according to our inclination" (Werzer, 1975, p. 236). Integrity thus can be developed as one matures through life (Cox et al., 2003); as such, it is dynamic and can be established by an addict during the course of recovery.

Quinn (2009) posited a social conception of integrity using the work of Charles Taylor and Lawrence Langer to provide the foundation for an integrity of the self. For Quinn, integrity has a social, communal aspect. She asserts that engagement with community can contribute to, diminish or help to restore one's integrity (Quinn, 2009). This resonates with the African conception of *ubuntu* — where a person is considered to be a person because of others — and also with the intention of the addiction recovery group. For many people in recovery, it is important to be of service to others — not only does this contribute towards making restitution for the damage they have caused through their addiction (even if their service is not necessarily to those who were affected), but it also demonstrates the shift away from the selfish thinking that characterises addiction, to being able to care for and consider others. These altruistic behaviours contribute to restoring the compromised integrity of the recovering addict.

9.2.2 Exploring the capacity for honesty

This section is in part written from my own clinical experience of thirty years and specifically from working with addicts.

There is a complex and reciprocal relationship between honesty and the construction of the integrity of the self. To be capable of honesty, the self needs to have integrity — i.e.

have balance or 'internal consistency' — and be whole. The ability to be honest rests on the stability and integration of the self. Stability and integration here imply a consistency between what one feels and thinks inside the self — one's personality or character — and how one behaves in the world — what one says and does. If there is consistency, and one's inner thoughts and feelings and behaviour are congruent, it is said that one acts with integrity or authenticity. This implies that honesty and integrity require a person's thought and emotional processes to be 'in good working order'. Someone trapped in an addictive cycle where the addictive substance must be acquired by any means necessary (which could include lying, stealing and neglecting responsibilities) and in which their affect (thoughts and emotions) is modified by mood-changing substances, does not have a mind in good working order.

Honesty requires discernment as to how our actions do or do not fit within rules and expectations of the other in context; it thus has a socio-cultural component.

The opposite of fragmentation is integration, and a person who is well integrated can be seen to be able to draw on many inner resources to process feelings and modulate responses — which implies having a certain resilience. In fact, McLeod (2004) notes that while self-protection is usually seen to be negatively correlated with integrity, a degree of self-protection is consistent with integrity as it preserves the internal consistency of the psyche.

If someone has these capabilities, it is presumed that they would not need to lie to preserve the self. Such a person is considered to be resilient and to have self-efficacy. This is similar to a person who is authentic — having congruence with both inner processes and external behaviours. Honesty thus has a relationship with authenticity which has a relationship with identity and, as such, assists understanding of the transformation of the addict's identity through recovery.

To be authentic refers to something of undisputed origin and not fraudulent (Lexico, n.d.). With regard to a person, it can be applied to the insight developed into how one has changed within oneself and one's life path according to one's values, interests, abilities, needs, opportunities, passions and personality. The existentialists emphasise that we have choice over much of the expression of this and, when applied to addiction recovery, this refers to the core of recovery and the future direction that one wishes one's self and one's

life to take. So, every day, and in every interaction, a person exercises their 'honesty muscle' — along with their freedom of choice to do so.

Phenomenological research conducted at a high school in Indonesia found that honesty can be developed in the classroom when the teacher has training in and understands the value of honesty as character education and then uses it to build students' self-confidence (Kadir et al., 2015). Teachers became role models of honesty in their engagements with their students. The desired behaviour [not specified] was rewarded and supported by parents and other family members in their environment (Kadir et al., 2015). Changes subsequently were documented in the students' behaviour in the formation of attitude, character, and manners — in relation to teachers and peers. In addition, there was a reduction of dishonest or deviant behaviours such as cheating. Such findings provide hope that through education, role modelling, practice and affirmation, honesty can be taught. This highlights the importance of role models in recovery practice, as is the case in recovery groups where role modelling is provided by old-timers.

Another study found that terminally ill patients in Sweden valued honesty from their caregivers as they faced difficult issues and important decisions (Erichsen et al., 2010). Clearly, to be able to express themselves honestly in an atmosphere of acceptance where they would not be judged, but supported, was critical. In the recovery group, too, being able to speak honestly in an atmosphere of acceptance is important in order to do the work of recovery.

9.2.3 Morality and self-respect

Another part of the self to consider when examining honesty is the notion of self-respect, which, according to Kant, is closely tied to moral character (Dillon, 2018). Kant was the first major Western philosopher to put respect for persons, including oneself, at the core of his moral theory (Dillon, 2018). For Kant, self-respect derives from carrying out the duties of a good person, such as 'doing to others as you would have done to you' — often called the 'golden rule' (Bayer, 2012). Honesty assists with the delivering of those moral duties in relationship to oneself and others. As one does this, one gains a feeling of self-esteem which contributes to the moral building up of character (discussed more fully in the chapter on self-esteem) (Mauri, 2011).

Conversely, when one is derelict in one's duties to oneself and others (family, friends, work) and, in addition, commits harmful acts, it contributes to a feeling of dissatisfaction with and disrespect of the self, which amplifies the urge to escape through the use of one's substance of choice, thus contributing to the vicious cycle of addiction. Dishonesty becomes increasingly prevalent as the addict becomes increasingly focused on obtaining the addictive substance at any cost. The work of recovery thus involves restoring one's sense of self-esteem through good behaviour, or, as the AA aphorism says, 'doing the next right thing'.

9.3 EXPLORING DISHONESTY

Honesty can be better understood by exploring its opposite — dishonesty. Dishonesty involves the deliberate attempt to deceive. Whether through action or omission, dishonesty is self-serving. The life of an addict is likely to have many occurrences of dishonesty — toward himself and to others. This brings the addict into conflict with others. An addict may tell her manager she was ill — while, in fact, she was hung over. An addict may tell his spouse that he needed to go out to buy bread — while, in fact, he has hidden the bread to create an excuse go out to find his substance of choice. As the addiction progresses, the addict tells more and more lies — some to cover others. For example, lies such as, "I only had two drinks," "it was just a splash of vodka," "it was a light wine" or "someone drove their car into mine," attempt to minimise the severity and extent of the addiction to others as well as within the addict's own mind.

9.3.1 Potential gains motivating dishonesty

There are many potential gains which may motivate dishonesty. Lewis (2015) notes that the motivations for lying may including protecting another person, hurting another person, avoiding punishment, deceiving oneself, attempting to appear better or greater than one is, or protecting the self from painful or difficult feelings. These may include humiliation, guilt or shame.

For many people, dishonesty is motivated by a desire to maintain a close connection with someone — to gain some kind of intimacy which provides gratification. The irony is that

when dishonesty is used to achieve closeness it increasingly fragments the person and the hope of genuine intimacy with others becomes increasingly elusive. It could be argued that the more unstable and fragmented one's sense of self is, the more one believes that one could not survive rejection; dishonesty thus becomes a survival strategy for the fragmented self.

9.3.2 Losses resulting from dishonesty

Among the casualties of dishonesty are trust (something given to another for safekeeping) and integrity. These are precious resources which are easily underestimated and wasted; once damaged, they are difficult to regain (Bok, 1978). Even small acts of dishonesty, if discovered, can quickly destroy one's credibility and trustworthiness on a larger scale and, even if undiscovered, can set up the classic 'slippery slope' in which small transgressions and cover-ups lead to larger ones. Habits form, and harm is done first to one's self — the first victim being one's integrity as one's internal consistency and wholeness breaks down — and then to others. As one loses the inner coherence and congruence which makes up one's moral character or self, one begins to present oneself differently to different people according to the different perceived gains, losses and demands involved for oneself. In the cycle of addiction, where the sole focus of the addict is to obtain their substance of choice regardless of consequence, this plays out in different ways, with others' trust in the person damaged, and then lost, in the process.

The short-term gains which may be acquired through dishonesty are thus paid for in terms of one's personhood. As the addict compromises his integrity, the resulting guilt and disappointment with himself triggers a desire to repeat the addictive cycle to numb these painful feelings. The self fragments further as the cycle repeats.

As the person's integrity is destroyed through dishonesty, he may begin to feel that not only his words and actions are wrong but that he is "rotten to the core" (Cox et al., 2003). Dishonesty can thus segue into shame (discussed in Chapter 7), which suggests that the cultivating of integrity and re-integrating of the self through therapy during recovery could both help to resolve shame and build the person's capacity for honesty.

Dishonesty and the shame of oneself at a core level are linked to the dis-integration of the person's self and impacts their relationships with others. The person not only becomes increasingly isolated from intimate relationships with others, but also becomes increasingly alienated within herself — never being able to be fully at ease, but having to maintain continuous vigilance about which lies were told to whom. Active addiction is thus characterised by withdrawal from the world and a narrowing of the addict's life (Kemp, 2011) as the addict is consumed by her addiction and will go to any lengths for its pursuit.

Spero provided a glimpse into this reality:

> *I was just looking for the next fix — while having a fix. I was not free. I was a slave to the addiction. … You are a slave to this thing in your head all the time and it's horrible.*

This resonates with the description by Cox et al. (2003) of the loss of the addict's integrity resulting in a "hollowed out character … and a life closed off from the multiplicity of human experience" (Cox et al., 2003, pp. 41–42). The world of the addict narrows in terms of time and space as she is ultimately held in the tyranny of the addiction (Kemp, 2011, 2018); the self is fragmented as integrity in her thoughts and actions is destroyed and the capacity to live a meaningful and satisfying life is lost.

9.3.3 Denial in addiction

Denial refers to the refusal to admit a particular state of reality. It is not the same as deliberate dishonesty as it involves self-deception and thus has an unconscious component as well. Denial is an integral part of addiction and thus is an important consideration in addiction recovery.

Johnson Taleff (1997) argues that addiction is impossible without the state of denial as a person of sound mind will not knowingly damage or harm himself or others. For such a person to continue in addiction indicates that some of the destructive aspects of his actions are placed outside of his conscious awareness (Taleff, 1997). Denial, in this context of addiction, is thus an unconscious defence mechanism — a contrived artifice of the psyche — that includes a range of psychological strategies intended to reduce the addict's

awareness that the use of the addictive substance is the source of their problems, rather than the solution.

The addict uses both conscious and unconscious forms of self-deception to maintain her addiction. The wake of destruction caused by her addiction is usually obvious, but the addict attempts to hide this reality from herself and perpetuate the illusion that there is no addiction problem. Typically, the addict is the last to admit that there is a problem. Empirical evidence demonstrates that denial is the number one reason cited by alcoholics for not seeking treatment (Grant, 1997; Pal et al., 2003; To, 2006; Wing, 1995). It is only when the evidence of the destructiveness of their behaviour becomes too overwhelming to ignore — when they 'hit rock bottom' — that many addicts even consider entering rehabilitation with a view to recovery. Sometimes it requires a dramatic situation or event which ruptures the way the addict perceives her life — such as a serious health problem, a car accident, a family intervention, or being forced to face the consequences of their actions, such as having injured someone — to bring the addict to this point. This was the case with most of the study participants. However, in the case of two, it was less dramatic: they eventually reached a point where they felt they were unable to continue living a life of addiction. They were 'sick and tired of being sick and tired'. Their denial had worn thin.

An addict is unable to participate in a recovery process when she is in total denial. First, she needs to accept that there is a problem before she can be willing to explore other ways of being and thinking and responding to emotions as potential solutions, rather than defaulting to her substance of choice as a solution for everything. Because of the key role which denial plays in addiction, the first step of AA is to admit that you have a problem (AA, 2001).

9.4 STUDY FINDINGS ON HONESTY AND INTEGRITY

In terms of findings in this study, all of the focus group participants named the restoration of integrity as the most important competence that they had learned in the recovery group. They named breaking denial — a competence they had to learn before they could develop integrity — the second most important.

9.4.1 Dishonesty in the group

Honesty is vital in a recovery group. Dishonesty can undermine the safe and sacred space that the work of recovery requires. At the same time, where else can addicts in recovery undergo the difficult process of change and experiment with new behaviours than in the group? It is therefore not surprising that there will be instances of dishonesty as members try out new ways of being, and often lapse back into old ways of being, in the safe space of the group.

Learning to recover and choose honesty begins in the group by talking openly about one's habitual lying and dishonesty. This is hard for many and some continue lying in the group. The complex interplay between the addict and her perceptual constructions of the group and its dynamics were described by Spero:

> *Lying to the group is big problematic as if you do it pushes you into isolation. You lie to the group and you're taking them for a fool. It works funny 'cause suddenly you can't trust them 'cause they haven't caught you out. So, you withdraw from the group because there is a double bind going there and they don't know what you've just been doing and so that puts you into isolation. So instead of being a place for safety, the group becomes a place of threat. And if it goes one, two, three, four, five, six weeks and you are still lying, you won't go back to the group because you can't handle this tension that is in your mind between when you lied and having to admit it six weeks later. So, the longer you get away with it, the worse it gets.*

Here we can see the dynamics between the addict's deceptive behaviour (lying), how it affected their relationship to the group, the build-up of tension through living a lie and not being found out and then either having to admit the lie or leave the group and become isolated again. Through this behaviour the addict sets herself up for a possible relapse by cutting off support, isolating herself and triggering shame.

Bob commented strongly on this:

> *It's counterproductive and pointless because in the end you are just lying to yourself. And if I had to lie about one year seven months, I'd feel so bad about it because that's a long time being sober. Don't lie about shit like that: no one's*

> *going to judge you; just be honest. You have to be honest: it's not going to help you if you are lying about if you had a drink and you don't tell people about it — it's bullshit. If I did that, and lied to the group, I don't think I would come back 'cause I wouldn't be able to face the people here, or myself.*

Bob, as someone with a longer time in unbroken recovery (one year and seven months of 'clean time'), conveys a clear sense of confidence in himself, the group and the recovery process. Implied is the importance of each participant putting his or her own needs first and sharing them in the atmosphere of acceptance and trust in the group.

Bob's final two sentences demonstrate the development of conscience and integrity in the addict who has chosen to participate in the group. He now had a conscience that was indicative of his choosing and wanting to live a good life.

Some of the study participants mentioned the issue of lying in meetings. Bob expressed anger towards those who had been dishonest through their words or behaviour; he showed his appreciation of the group as a 'clean' space and a place of recovery:

> *Everybody must be honest. If you're not honest, you're kidding yourself and you can see those people who aren't being honest — you can see those who aren't really interested in recovering. It takes up time from other people who really need the help — who are willing to accept the help. Why bother coming here if you know you are just going to go off and drink? Why bother coming here if you aren't going to accept the help?*
>
> *When someone lied in the group* [could smell alcohol on them]*, I got a bit disappointed. It irritates me — everyone else here is trying to recover.*

Bob's expectation of honesty was clear, as was the disappointment and annoyance that he felt when experiencing dishonesty from someone he had trusted. Through these experiences the participants also experienced in a small way what their own families did when they lied. This could generate a sense of empathy for their families, which could help to motivate the addict to reconcile with them.

When dishonesty happened in the group, the possibility for a participant to remain in the group and admit to, and process his feelings, without having to act on them, allowed him to build his own capacity for the tolerance of uncomfortable emotions. The participant

did not have to resort to taking a substance of choice or leave the group (albeit temporarily) because the intensity of the emotions was too much. It also allowed him to reflect on his stand on dishonesty in recovery and thus learn and grow from these experiences.

Karen's comment below refers to an implied breaking of trust and the triggering of her suspicion towards the participant who did not report her clean time days accurately. This also reveals her underlying assumption that people would be honest in the group:

> *That's why we get so upset when people cock up their days* [when they report them at the beginning of the meeting]*, 'cause that's not what you said last time! And if they say the wrong days I think, "Did she really cock it up or is there a problem?"*

Being emotionally close to another person is hard for the recovering addict and it is not surprising that members were vigilant about each other's days, and that when there was a perceived inconsistency in reporting it created uncertainty and a possible rupture in the trust until it was resolved. It also indicates that the participants looked for integrity and consistency in each other and were concerned when they did not find it.

The emotional intensity of Bob and Karen's words, above, reveal the importance of the issue of honesty in the group.

Dishonesty in recovery is dangerous for many reasons. Once the addict finds herself lying, even about a small thing, it is a relapse trigger suggesting that she may be returning to previous problematic coping strategies. The lying in recovery can indicate that she has stopped being entirely honest and she may be avoiding facing aspects of herself or her life. This can trigger feelings of guilt and shame. In addition, once others discover the addict has lied it can further break down any trust that may have been regained, and this can cause the addict to feel disheartened and judge herself harshly and trigger shame. It was these feelings, in part, that kept her trapped in addiction. If she allows self-deception to once again take hold, she is likely to question the value of sobriety and the need to refrain from addictive substances. Recovery from addiction needs constant vigilance and attention.

9.4.2 Breaking denial

One cannot recover integrity without breaking the pattern of denial. Stephen, an addiction counsellor in the recovery group, provided a good overview of the relationship between addiction and denial:

> *So, you started drinking 'cause you had a problem and thought that would be the solution. Now you still have the problem, which has most probably gotten worse. And you have a helluva lot more problems on top of that initial problem. And you've also got an addiction … a brain that requires the drug; that has learnt that it wants the drug — a brain that keeps telling you that it needs the drug. … What do we require to recover? We require our brain, our thinking. But that's the part of us that is sick. It's like putting plaster on my arm with the broken arm. And to understand that it's not your whole brain that is sick: parts are fine. But the sick part tells you that it's ok to carry on.*

This illustrates the importance of needing to break through denial in order for the addict to begin the process of recovery.

A clear example of the power of the addiction recovery group in opening up denial — in this case, psychological defensiveness — is illustrated in the following excerpt, where Spero articulated beautifully his experience of the 'penny dropping' and the breaking through of his denial:

> *The … group lambasted me. … I kept saying, "But … but … but …" and they kept saying, "There are no 'but, but, buts'. We do understand." From the group who attacked me with honesty and love and called me on all my bullshit. They were all ridiculing me in a way that I got it. And I had to slow them down. It was so shocking when they were saying it — I had to slow them down to really get it. I wanted the moment. I knew it was truth and I had to slow them and get the truth. They didn't tell me in a nice way: they told me, "Shut the fuck up!" Bless them!!*

Spero's description shows the interplay between the group, who had a message to convey, and the participant who, though initially defensive, wanted to hear it even though it was difficult, and eventually let it in and was transformed by it. We see the breaking open of denial by the dialogical process between the group and the recovering addict.

Because of the history of trust and respect that had built up between members of the group, Spero was able to feel sincerity and empathy from the group rather than feeling attacked, judged and shamed. He saw that the group genuinely had his own best interests at heart. This allowed him to take in what they were saying to him and start challenging the areas he was in denial about. This calling out of one member by others is critical to recovery and is known in communities of practice terminology as the 'regime of competence'; it is discussed in more depth in Chapter 13.

The way the group did this was by focusing exclusively on Spero and responding to his resistance in a humorous way — in an atmosphere of lightness and acceptance — while not letting him get away with any kind of thinking and rationalisation that would collude with his denial. They thus 'woke him up' by not letting him get away with anything and yet allowed him the time he needed to process what they were saying to him: to focus on himself and build up his sense of self from within himself — not from something outside of himself, as is the pattern with addiction.

Another important aspect here is Spero's desire to hear the group — his choice to let the message in — which demonstrates integrity developing within the self through active choice. Spero's personal struggle and wanting to recover is evident in this process.

Spero recognised there was a special quality to the interaction with the group which he called 'truth'; the group was there for him, allowing him to take his time and to internalise what they were saying such that something very profound transpired between the group and himself and he felt deeply grateful. His use of the expression 'bless them' reflects the integrated, grateful and whole nature of his experience. His capacity to not resist their message but, instead, to let it in and experience gratitude, demonstrates how far he had already come in his recovery journey.

The notion of truth is an antidote to both unconscious denial and to the conscious deception and dishonesty of addiction. Truth implies an authenticity of self, a fidelity to a sense of being. In this example, we get a sense of the reconstruction of self occurring in the group as a result of its commitment to challenging and dispelling denial.

Because of the unconscious aspects of denial, breaking through it requires an awareness of the addict's 'blind spots' — of which she herself is not aware. This is where the versatility of the addiction recovery group is powerful in that it accommodates a variety

of people with their various mechanisms of denial, depending on the individual and their issue. This is helpful because members each have different blind spots, and can thus see each other's. Some may be intellectually incapacitated and not understand certain aspects of recovery, whereas others may feel they have a moral failing, or even others still may be defensive around doing introspective work when the psychodynamic perspective is applied. The inherent diversity of the group thus provides the means for integration of the different conceptualisations of denial and a way of working with them.

9.4.3 Cultivating honesty in the group

There are two aspects involved in the recovery of honesty: one is the recovery of one's honesty with one's self (breaking denial), the other is the recovery of one's honesty with others (making amends, taking responsibility, speaking the truth). Many of these resonate with aspects of the twelve-steps.

The cultivation of self-awareness is foundational in the recovery of honesty. The issue of being honest with oneself has been explored by many philosophers — including Plato and Kierkegaard, as well as David Hume (2015) in his work *Philosophical honesty*, which ends with the line: "Philosophy, after all, is about Truth. But what good is Truth if we can't first be true to ourselves?".

Only once someone is authentic to themselves are they are capable of being truthful and honest to others — a key part of being a fully functioning human.

This process, as it occurred in the recovery group, was explained by Mervyn:

> *One needs to be honest with themselves, firstly. You need to go out there and tell the people that you let them down or caused a problem for them, and to apologise. You need to explain to them that the reason you did that was because of being an alcoholic. They are not going to believe you; you are going to need to convince them. In order to convince them, you are going to have to be sincere and once you start being sincere to the person that you have done harm to then slowly — not overnight, because it's not an overnight process — they see Mervyn has now changed. He is keeping up to his word, his promises and he is trying to make a new life. And they will automatically make a decision on their own as to whether*

they can actually trust you, or not. The important word here is that you have to go there and be very convincing — in a nice way — and explain to them that all the nasty deeds that you did was when you were under the influence. But they are not going to believe you straight away: it's very hard work for you to get back the respect, the trust from other people. ... In a nutshell, you have to prove not only to that person, but to yourself, that you are changed.

Here Mervyn states that in order to be honest with others, one has to be honest with oneself. He goes on to explain the process of 'coming clean' to others, beginning by outlining various aspects of his addiction recovery to them, which would not be possible had he not done (and were he not in the process of doing) the work first, within himself. He approaches those whom he has harmed or wronged — which means facing up to what he has done and revealing the breaking of denial within himself. This admission to himself is the first step towards the cultivation of honesty and integrity.

He begins talking to them by frankly admitting that he is an alcoholic — this indicates another aspect of the breakthrough in his own denial by being able to admit that he is an addict to others. In being prepared to share this with others, he indicates an acceptance of this part of himself. He shows he is taking responsibility by owning up for what he did, confessing to things that they may not have even known about in the spirit of making a genuine disclosure. This shows a deliberate attempt at honesty. We can see illustrated here the congruence in integrity between his thoughts and his actions and speech, revealing the consistency indicative of integrity.

He speaks of being sincere — implying genuineness and openness and an understanding of what this means. It is implied that others may question him until they are fully satisfied that what he is sharing with them is true and that he is in the process of changing. He is aware that this is asking a lot from those he is sharing this with and that they need time and he shows them the empathy he has clearly cultivated for himself through the group interaction by revealing his insight that they will not believe him straight away. He understands this because he knows innately for himself that the process of believing and trusting again takes time. He knows this because he is living it.

He realises that, as time passes, those he has spoken to will be looking for a consistency from him in word and behaviour, which is a demonstration of his integrity. He is ready to

risk relationship with them again, which he demonstrates when he says, "they will … make a decision on their own as to whether they can actually trust you, or not," which shows another aspect of integrity. He is making peace with the fact that he cannot control others but, in doing the right thing, he keeps his conscience clear and allows others to make good choices for themselves. The hold of his addiction slowly relaxes for all those who have been affected.

In saying that it is "hard work", Mervyn also reveals a change in himself — having moved from the 'quick fix' of addiction to accepting that some things do take time. His tone is confident and there is a strength to his words which suggests that he is developing resilience in the face of potential rejection. His self-esteem would be strengthened from participating in interactions such as this one, where he is motivated not so much by trying to achieve an outcome as by the commitment to do the right thing for himself. And this speaks to integrity and choosing to live a good life.

The recovery of honesty is a gradual, subtle and fraught process. Ultimately, the aim is to be able to live an ethical life, build up one's self-esteem, and be strong enough to be able to risk and survive rejection without having to soothe painful feelings with substances. This is the test of integrity. As we see, this process occurs in its embryonic state first within the recovery group, and then grows and widens out. Mervyn captured this:

> *Honesty about being an addict, accepting and admitting who one is, is how it begins:*
>
> *People should be encouraged to let their friends know that they are alcoholics. I was open and honest with everybody and I really didn't care what they thought.*

Karen shared how she had brought her habitual dishonesty as an addict into the group, revealing that the recovery journey consists of many learning experiences and for some, many lapses and relapses:

> *When I lied about my days* [clean time], *J* [another participant] *knew. And it wasn't nice to lie about my days and act like things are fine, when they are not. I was so focused on getting through the meeting and not tripping up on my own lies. It wasn't worth it. That's when I used to skip — remember? Now I have a promise to make a meeting a week, and I'm keeping it.*

Karen initially pretended that she had a certain amount of clean time and experienced herself in the group presenting as if she was fine while inside she was struggling. During those sessions she experienced inner conflict, as she had placed herself in a position where she had to keep up with her own lies, which caused additional stress to her which she 'solved' by skipping meetings. She wanted to be well regarded socially but learned that this strategy resulted in a further fragmentation of self and alienation of herself from real connection with others, cutting herself off from much needed support for recovery and resulting in her dealing with that by resorting to skipping meetings.

Over the course of her participation in the group, Karen would have witnessed other participants sharing their difficulties and would have observed their healing and been present as they grew through the group process. Witnessing the recovery of honesty in others would have influenced her own choice to live and act with more integrity herself, as evidenced by her promise to herself to attend a meeting a week. The congruence of her internal decision and external action is indicative of her developing integrity. It is also likely that as she compared her own deceptive approach with others' authentic participation, she became motivated to change her behaviour.

It is a reciprocal process — both having a resilient sense of self with integrity and cultivating that at the same time. Having integrity even at the basic level of not 'editing' what one says is important, as even that impacts on one's recovery. Karen spoke about the development of conscience and how it requires full engagement:

> *If you haven't been honest in your feedback about the big things, then it affects your recovery. No recipe uses half an egg. You have to put the whole egg in. … If that's in your heart, that's what you share.*

Karen's illustration of "put[ting] the whole egg in" serves as a symbol for integrity — the regaining of and acceptance of the whole self.

There are many nuances to the complex phenomenon of the recovery of honesty and cultivation of integrity in the addiction recovery process. Pulling some of the strands that emerged from the various interviews in this study together here, it is evident that the cultivation of honesty is a process which involves making choice after choice to do so. For some, it involves bringing increasing amounts of personal information into the group as trust is built, whereas for others it is about enacting the deceptive behaviour in the

group, experiencing the internal isolation that results and becoming aware of the options of either confession (which would trigger shame) or leaving the group.

The cultivation and expression of honesty allows for the healing of the addict and those close to them. Conversely, should the addict continue to be dishonest then it means that this healing will not take place and instead further damage and fragmentation of the self (due to lying and dishonest behaviour) will be perpetuated. This dynamic illustrates how the addict can set himself up to relapse.

9.4.4 'Clean time'

In the recovery group, 'clean time' refers to the number of days a member has gone without using an addictive substance. At the beginning of each meeting each member reports his or her 'clean time' as a means of assessment. This cultivates honesty in the group and also reminds everyone that the process of recovery has a measurable outcome: one's clean time is an objective measure of one's sobriety. Karen explained:

> *My days* [accrued clean time] *keep me clean. Imagine me starting from one again. I've come in here and lied about it. I don't think I could come back if I relapsed. … My days are my incentive.*

Here Karen talks about using her days as a tool to keep her clean. Implied in the term 'clean' is a reference to honesty insofar as "coming clean" means telling the truth about something one has been keeping secret. She refers to how much she would lose in having to begin counting from day one again because each day in recovery matters. And many of those days are battles, in which she was victorious. They count and she counts them. It also suggests that the self that has been recovered would risk being lost due to the relapse.

Implied too is the reference to shame — that she would not be able to come back to the group should she relapse, as it would mean having to face her failure at sobriety and the thought of that seemed unbearable. So, in an indirect way, honesty is cultivated not only as an incentive but also as a disincentive insofar as group participants are likely to not want to face the consequences of confessing relapse to the group.

Karen noted how the culture of honesty in the recovery group influenced her life:

> *It's so easy to be deceptive and conniving and manipulative when you're an addict. But to sit here and be honest in this meeting … it's spilled over into my life … honest living, brook no secrets.*

She communicated a sense of relief in being able to be honest and no longer having to live a life of keeping track of the different lies she had told different people. She attributed the honesty now characterising her life to her experience of honesty in the group. This implies that she went into the group and found a sense of acceptance and understanding, which allowed her to be fully honest with the group. This new ability to be honest and open allowed her to create a sense of integrity, which she could then implement in the world outside the group because she no longer needed to use lies and deception.

9.5 CONCLUSION

At the heart of recovery is honesty. When a participant is dishonest in a recovery group, it may be an indication that she is vulnerable to relapse. However, for the recovering addict to learn to recover honesty, she needs the group to act as a holding space that allows her to be dishonest — either consciously or as a result of her state of denial — and that responds to her with firmness and understanding. Like any new skill, honesty needs to be practised. As the addict risks aspects of her self in the group, she grows in integrity. This chapter has demonstrated how the recovery group can aid each member in the process of dismantling denial and developing integrity. The participant then takes this experience in the group to the outside world, where it boosts their awareness, honesty and resilience to make amends and establish a new way of life with restored integrity.

The following two chapters focus on the psychological aspects of, firstly, empathy and mentalisation and then, secondly, self-esteem and self-worth. These psychological capacities emerged in this study as essential to the recovery of the group participants, allowing them to focus on others and to develop themselves positively — both vital antidotes to addiction.

CHAPTER 10
PSYCHOLOGICAL MECHANISMS: THE ROLE OF EMPATHY AND MENTALISATION IN RECOVERY

10.1 INTRODUCTION

The previous chapter examined the significance of integrity and honesty to recovery, and explored how these were developed within the addiction recovery group. This chapter explores two additional aspects of social learning: empathy and mentalisation. Both of these capacities enable a person to meta-process what is happening within herself and others. The ability to focus on others is critical to social learning, and fundamental to addiction group recovery. While under the power of addiction, however, an addict is unlikely to be able to use either of these skills successfully, yet both are critical to relating well to others and to overcoming addiction and maintaining recovery. This chapter explores how these skills were built through interactions in the addiction recovery group in this study, and how they contributed to addicts being able to sustain their recoveries.

10.2 UNDERSTANDING EMPATHY

Empathy is the ability to imagine oneself in another's place in order to understand and respond to other's feelings, ideas, or emotions (Decety & Jackson, 2006; Krämer et al., 2010). Empathy has been described as "the naturally occurring subjective experience of similarity between the feelings expressed by self and others, without losing sight of whose feelings belong to whom" (Decety & Jackson, 2004, p. 71).

The capacity to empathise has been defined as "… the spark of human concern for others […] The glue that makes social life possible" (Hoffman, 2001, p. 3). Indeed, empathy is essential for the creation and preservation of emotional bonds between mother and child, partners, and larger social groups (Singer, 2006). It is also considered to be an important aspect of caring for another, in which interpretations based on observation, memory, knowledge, affect and cognition are integrated in order to make inferences regarding the psychological processes of the other (Singer & Tusche, 2008).

The essential role of empathy in emotional and interpersonal life has been underscored during the last decade. Empathy is a critical aspect of social cognition — the capability of reading and responding to others which is fundamental to making and maintaining relational bonds and adapting to social settings (Anderson & Keltner, 2003). It facilitates moral reasoning and is the basis of altruistic decision-making and action (Batson et al., 1995).

10.1.1 The components of empathy

To be empathic, one first has to be able to understand one's own feelings and emotional state. Building the capacity to identity one's feelings and to self-reflect improves one's capacity for empathy (Singer & Tusche, 2008). The development of both of these aspects was evidenced through the recovery process in the group.

Empathy has been considered to consist of three separate components: 1) the affective response to another's emotions and actions (Chakrabarti & Baron-Cohen, 2006; Lawrence et al., 2004); 2) "the cognitive processing of one's affective response to the other person's perspective" (Gerdes & Segal, 2009, p. 114); and 3) the voluntary choice to act and behave empathically (Premack & Woodruff, 1978). Gerdes and Segal (2009, p. 114) posited that "[m]irrored emotional responses are involuntary, while cognitive processing and conscious decision-making are voluntary. … The cognitive aspects of perspective-taking, self-awareness, and emotion regulation can be practiced and cultivated". The affective component requires healthy neural pathways.

Empathy in addiction

Empathy is a key emotional competence that is linked to addiction at the juncture between intrapersonal and interpersonal abilities (Singer, 2006). Addicts have been found to have impaired social functioning, where chronic drug consumption may lead to difficulties in empathic attunement to others (Heilig et al., 2016). Research has found that the cultivation and development of empathic skills is an important aspect of relapse prevention and should be included in rehabilitative programmes for addicts (Ferrari et al., 2014).

Two studies conducted by McCown (1989, 1990) examined empathic deficits in substance abusers. The first study revealed a positive relationship between empathy and abstinence within twelve-step groups, but the second study failed to prove this with relapses assessed at a year. Perhaps the reason for the positive correlation lies in the social (learning) aspects of empathy evidenced in the first study.

Other studies have revealed diminished empathy in those using alcohol, cocaine (Martinotti et al., 2009; Maurage et al., 2011; Preller et al., 2014), methamphetamine (Homer et al., 2008) or other substances (i.e., alcohol, cannabis, cocaine, opiates, and benzodiazepine) (Ferrari et al., 2014). With all participants showing reduced empathy and higher levels of personal distress, it can be concluded that substance addiction reduces empathy regardless of the substance of choice. Other studies have found empathic deficits among substance abusers, implying difficulty with emotion management and the accurate perception and tracking of social situations (Tomei et al., 2017). Maurage et al. (2011) supported the notion that individuals with lower levels of affective empathy may be more prone to using alcohol as a coping strategy due to a more frequent experience of social problems.

A low level of empathy was observed in a study of pre-morbid alcoholic personalities; it was hypothesised that latent abusers found something in alcohol misuse that enabled them to compensate for their emotional deficits (Martinotti et al., 2009). Other researchers have pondered whether diminished empathy, early distressing emotion (trauma) and ineffective emotional regulation occur in addiction, which then, in turn, impairs emotional awareness, stability and regulation (Tomei, Besson, & Grivel, 2017). It has been suggested that these factors in fact cause the development of self-oriented emotions in the addict (Batson et al., 1995; Eisenberg et al., 2014), which then, in turn, prevent the individual from seeking out and developing empathic skills that enable them to focus on the other (Decety & Moriguchi, 2007). This suggests that emotional regulation (discussed later in this chapter) underlies problems with empathy, rather than the other way around. Empathy deficits could thus play a role in unmanaged psychiatric difficulties such as depression and anxiety, which then concurs with Khantzian's self-medication hypothesis by suggesting that addiction could be an attempt to self-medicate (Thoma et al., 2013). In another study, it was found that the level of empathy was significantly lower in the group of alcohol-dependent subjects than in the control sample ($p < .001$) (Martinotti et al.,

2009). Understanding the role and relationship of empathy in the addicted population is important for determining treatment interventions. An effective rehabilitative programme requires a focus on the empowerment of the patient's insight on their empathy impairments (Tomei, Besson, Reber, et al., 2017).

Problems with empathy deficits have been shown to affect mental processing, including morality (Batson et al., 1995). Substance abuse has been identified in the literature as a risk factor and trigger for criminal behaviour (Chassin et al., 2003; Menard et al., 2001; Mumola & Karberg, 2006; Ruiz et al., 2012) and intoxication as a predisposing factor (Boles & Miotto, 2003; Lundholm et al., 2013). Empathy deficits thus have wide personal and social implications for the lives of people with addictions and those close to them (Hulka et al., 2013).

Other research has found links between deficits in empathy and problematic interpersonal interactions and difficulties, as well as a low emotional quotient (EQ) score (Bagby et al., 1994; Spielberger, 2010). In addition, a vicious circle has been identified where impaired empathy could increase difficulties in cultivating and maintaining enriching relationships, resulting in social isolation, which in turn leads to seeking out the substance of choice, which could be a strategy to face and moderate loneliness, which is associated with addiction (Kornreich et al., 2002; Maurage et al., 2011; Uekermann et al., 2007). The dictum that the opposite of addiction is connection is salient here, and empathy is one of the components of this connection.

10.2 MENTALISATION

Another aspect of social learning and component of connection vital to addiction recovery is the concept of mentalisation. Mentalising refers to the ability to cognitively represent the mental states and emotions of others while remaining emotionally detached from them oneself (Singer, 2006, p. 252). The flexible neurological interrelation associated with attention, cognitive control and mentalisation allows for empathy with others as well (Keysers & Gazzola, 2014). Mentalisation and empathy are thus closely related, and the theories related to both are useful to the understanding of participants' experience in this study.

Mentalisation is the ability to understand the intentions, goals and emotional states of ourselves and others (Bateman & Fonagy, 2004). It allows us to create mental models in order to differentiate between ourselves and others to regulate affect, name feelings and organise our experience (Fonagy et al., 1991). So being able to infer the mental states of others, or 'mentalising', is a necessary precondition in order to empathically respond to others (Frith & Frith, 2003). Indeed, empathy requires the sharing of that experience while keeping both individuals' emotional states separate (Decety & Jackson, 2004; Singer, 2006). Mentalisation as a concept was put forward by Fonagy et al. (1991), whose theory and model of mind show how one could think about one's feelings while one feels them. This provides a mechanism to see oneself as separate from others and to regulate emotions and cognitions based on a theory of mind (Fonagy et al., 1991). It involves being able to think about our feelings at the same time that we feel them in order to control our emotional states by being able to identify them, control how long they last and how intense they are, and to express in words how we feel to ourselves and to others. This emotional regulation is linked to action and behaviour.

Mentalising is important to well-being in several respects. It is the basis of self-awareness and is linked to identity, agency and control over ourselves and our environment (Fonagy et al., 1991). It provides a means to have an implicit and explicit continuous and cohesive sense of self, making moment-to-moment assessments needed by the various demands of our lives. It allows us to focus on others and attempt to see things from their perspective, which is fundamental to healthy and functional interactions (Fonagy & Allison, 2013). By doing this we are able to adjust ourselves by evaluating the responses we get from the other (Fonagy & Allison, 2013). In this way, we achieve 'connection' with the other via a mutual meeting of minds and feel seen, heard, accepted, understood and validated.

Mentalising makes reciprocal and enriching relationships possible by allowing one to mediate inferences of self and other in the moment in a flexible way by accommodating both oneself and the other (Woodier, 2011). Mentalising is fundamental to resilience — being able to bounce back from challenging situations. Research findings increasingly reveal that those who are unable to mentalise in situations of difficulty and trauma are vulnerable to psychiatric and addictive disorders (Savov & Atanassov, 2013). On the other hand, the ability to mentalise enhances one's quality of life in many ways (Allen et al., 2003).

10.3 EMOTIONAL REGULATION

Deficits in empathy and mentalisation link to another aspect considered essential for interpersonal functioning — namely, emotional regulation. As we have seen, the ability to think about thinking and make inferences regarding the other as separate from oneself gives one a sense of control and thus choice over one's response (Gross, 1998). This process involves various psychological strategies (Gross, 1998). Emotion regulation is critical for appropriate expression of socially appropriate intensity of emotion which impacts on behaviour (Aldao & Christensen, 2015; Christensen & Aldao, 2015; Eisenberg et al., 2002; Gross, 2013) and empathy (Eisenberg, 1996; Eisenberg et al., 1999). Those who are incapable of emotional regulation have been found to have longer and more intense periods of emotional distress, leaving them vulnerable to mental health problems, substance abuse (Tull & Aldao, 2015) and risk-taking behaviours (Weiss et al., 2015).

Addictive substances have been found to assist the regulation of emotions in those who have such difficulties, increasing emotional states such as euphoria (Cooper et al., 1995) while soothing difficult emotions (Baker et al., 2004). Those who are unable to sufficiently emotionally regulate are vulnerable to substance misuse (Berking & Wupperman, 2012; Sher & Grekin, 2007; Weiss et al., 2015). There are strong links specifically to personality and mood aspects such as depression, anxiety, sensitivity, impulsivity and sensation seeking (Cloninger, 1987; Sher et al., 2000; Woicik et al., 2009).

Problems with mentalisation are linked to addicts' struggle with relationship difficulties at an emotional level. Their inability to manage their emotional states can lead to their reaching for their substance of choice. It has been theorised psychodynamically that addicts have impairment in mentalising and this has been linked with early attachment issues (Savov & Atanassov, 2013; Weegmann, 2016; Weegmann & Khantzian, 2017).

10.4 BUILDING THE CAPACITY TO EMPATHISE AND MENTALISE

According to Maslow "[b]eloved people can be incorporated into the self" (Maslow, 1967, p. 103), and this is how a person builds the capacity to mentalise and empathise.

Beloved people can include caregivers, friends, teachers or fellow recovery group members. A key component of empathy and mentalisation is the person's ability to mirror the mind of the other. Mirroring is "the process by which a person attunes to the other's inner world and provides them with the words and behaviours for self-expression" (Cozolino, 2013, p. 52). The basis of this is attunement to the other, which is found in many close relationships and interactions, including those in the recovery group.

Human beings, however, may mimic indiscriminately and without discernment (Byrne, 2005). Iacoboni (2013) suggested that imitative violence has played a role in the committing of atrocities. This is when imitation gives way to aggression without thinking through the consequences. As such, we learn addiction in a similar way to learning recovery — via mirroring and imitation. It is essential, then, for the recovering addict to develop the capacity to mentalise so that there is a reflexive component to his behaviour. For Gerdes and Segal (2009), it is important to not only link action to affect and cognition, but to nurture action that is positive. The group conditions and mechanisms which facilitate this are thus essential to recovery.

10.5 EMPATHY IN THE GROUP

Empathy works in two ways in the addiction recovery group. The first way is when a new participant experiences being understood, seen and accepted — usually by an old-timer in the group, who is credible for being further along the recovery road than the new participant. The other way is when that participant becomes capable of displaying that same understanding and empathy to another group member. This indicates that she has developed the capacity to consider and put herself in the shoes of others and is not solely focused on herself. The quality of being able to consider another lies at the heart of both social learning and addiction recovery, and for many, emerges through participation in the group.

Participants in this study referred frequently to their own experiences of other members empathising with them. Comments often focused on someone in the group who was able to understand another participant's experience from their own, and reached out to that person when she was experiencing cravings — the hardest time of all in addiction recovery. Since the term 'empathy' is not commonly used by most people in daily speech,

references to empathy by participants often did not specifically use this term but referred to experiencing it either for, or from, another.

10.6 CRITERIA FOR EMPATHY IDENTIFIED IN THE STUDY

The comments of participants revealed that the following conditions existed in the group as a precursor for empathy to be cultivated in its members.

10.6.1 Genuineness

Stephen indicated what it feels like when someone responds empathically:

> *It makes group members feel more understood from a **gut** level.*

This refers to the experience of empathy that is hard to articulate, yet is felt — the experience of being heard and understood by another. This feeling is essential to have in the group for the work of recovery to happen. One has to have that experience, and have trust and confidence in those whom you let in to learn from, as this is a key building block in social learning.

10.6.2 Empathy during craving

Arguably, the most difficult time in recovery is when one is experiencing cravings. It is the time one feels most chaotic, desperate, disconnected, vulnerable and needy. Participants who understood the intense desperation of craving through their own experience were able to convey this empathically to other participants. The following extracts convey a sense of relief in being understood. They also indicate that the addict feels connected with others in the group and 'welcomed into the fold' at a time when they feel most alone:

> *People who do not know that utter, complete feeling — that if I don't have that drink or drug, I am not going to get through this day — won't understand it, how intense it is. Your whole being hinges on that. And they've all been there.*

Understanding it's not me who is crazy or weird or 'just pull yourself together'. — Karen

People in the group can empathise with me. They understand. Other people can sympathise, but they don't understand and you can't make them understand. Unless you've been through it, you don't really know. … I know some of the group are there for me. If I'm having a craving I message one or two of them and they say, "Don't worry," and we meet up. At least they know what you're going through. And that makes a helluva difference. — Bob

At least when I talk to someone from the group, they know what I'm going through. They tell me, "Take it one second, one minute, at a time." — Bob

The empathic responses are soothing, connecting and containing for the craving addict and can avert a relapse.

10.6.3 Kinship

Another aspect which overcomes the feeling of being lonely, alone and disconnected is the feeling of a reciprocated sense of kinship. The ability and willingness to use one's struggle as a basis to understand and assist others, because one has processed and integrated aspects of it, is meaningful to those in recovery. The feeling of at last being seen, heard and connected with can be extremely powerful for newcomers. Karen described her experience of this in the recovery group:

That they are there, just knowing they are there, and you can tell them anything that's bothering you, and how you are craving so much. And they just sit there and listen 'cause they know exactly what you are going through.

Bob explained that some of the reasons he came to group were

… the advice that you get, and hearing other people's stories, and knowing that you are not alone.

Karen noted that she found it meaningful to:

… see how other people are struggling with similar things to you, or to see how you can help somebody who is struggling with something that you […] are struggling with.

10.6.4 Empathy for discomfort within oneself

Participants in the study expressed that as members of the recovery group they found it particularly helpful that others could empathise with their experience of feeling uncomfortable within themselves. While previously they had attempted to relieve this discomfort by self-medicating with a substance, in the group they attempted to work with the deepest parts of themselves. The feeling of being uncomfortable within the ground of one's self is not an easy feeling to bear or to articulate. It thus brings a sense of connection, wonder and relief when one encounters others who share it.

Stephen described this:

Somebody who understands and who has been there, or done what he is talking about; somebody who knows what that feeling is like, who understands when people talk about feeling uncomfortable in your own skin, the meaning of that, that feeling of … something missing.

At the deepest level, this is what addicts share: the feeling of something missing. To connect with others over a feeling of emptiness and loss can be a deep and profound connection. Bob described this:

To be able to speak to people who understood how difficult it was; who had the same feeling of discomfort about themselves and how difficult it was not to have a drink or substance to make you feel ok, and to try and live feeling uncomfortable.

This bonding over a shared experience in an atmosphere of mutual empathy is the essence and foundation of the work of group recovery. Bob commented on this shared, spoken and unspoken knowing:

I am comfortable in that group. I can tell them all what I want to and I know they are going to understand.

Social learning is predicated on this. Without being able to feel relaxed, welcomed and part of the group, especially when at one's most disconnected and uncomfortable, it would be impossible to do the work of recovery and learn from others — or even teach them.

It emerged in the findings that through the experience of being empathised with by someone who has shared a similar experience, the process of learning to recover can take place — through letting someone in and beginning to work with the innermost parts of oneself that feel uncomfortable, missing and disconnected. Participants made several comments about how they felt closer to the other group participants than to members of their own families, and how they felt understood and able to talk to the group participants in a way that they did not with close friends and family members. Karen said:

> *I remember often hearing, here in the group, how people could talk about things in the group that they couldn't talk about to their husbands and wives, partners or friends. They felt more comfortable and understood. It's a big thing.*

Much of this can be attributed to empathy.

10.7 THE MECHANISMS OF EMPATHY IN THE GROUP CONTEXT

Without empathy, recovery cannot happen in a group context. Each participant must feel understood, validated, accepted and part of the group in order to learn how to recover; this happens through experiencing empathy. Stephen explained:

> *We get very stuck in addiction — in certain thought patterns, rituals, friends, belief systems — we get stuck in those and they cage us. It's to open yourself up to more possibility — and feeling heard and understood does that.*

The aspects of identification with a positive and credible role model who really understands from her own experience and can share this with other participants is critical, as is the willingness to want to open up to new possibilities and recover. The feeling of being understood opens that up and touches the parts of the addict that are the most wounded — the innermost feeling of something missing, fragmented, discomfort within one's skin — which are arguably the deepest longings which emerge when the addict is craving.

Because group members who are further along the path of recovery have experienced this but have worked with these feelings rather than only self-medicating with their substance of choice, they offer the newcomer a way forward with empathy, action and advice. Karen described experiencing empathy for new members, as an old-timer herself:

> *I wanted to show the newcomers that there are people who thought like they do, who felt like they do, who have similar problems and who are managing to cope, or learning how to cope and that they can. Every addict thinks that their personal pain — whatever it is that they use the drugs or alcohol to soothe — they think it's very unique, and that no one would understand: "You just don't know what I feel like" — without realising that other people really do know what you feel like, as they have mainly felt the same thing. It makes you feel you are not alone: connection.*

The sense in the group is that even though one is uncomfortable and what one feels is difficult, others feel similarly, and their intention is to assist as well as to find assistance. Opening up and sharing one's difficulties or cravings, and being heard and responded to with empathy, thus brings comfort and openness to finding a way forward. This is a process that is done together, reminiscent of the translated Zulu saying that 'one hand washes the other': the newcomers receive help from the old-timers, while the old-timers receive the opportunity to consolidate their own learning of recovery. Empathy unlocks the 'cage' of addiction, extended from an old-timer to a newcomer who is ready.

10.7.1 Learning to take a step back

In the following excerpt, we see how Karen gained insight into herself and developed skills to regulate her emotions. This extract illustrates the development of mentalisation in an addict in the recovery group. She learnt to apply the strategy of not responding immediately in order to give herself time to process the situation, cognitively and emotionally, especially if it involved other people — which she knew could be problematic to her.

Being an addict, I know my behaviours are very impulsive. I know I am quick to act. So, learning that I have to take a step back and think about things before I do them. And, without a doubt, interaction with others.

Karen was able to exercise other options over her life by giving herself a choice and not responding impulsively by displaying anger, for example, or reaching for a substance to calm herself down. The link with developing emotional regulation strategies in the group, based on learning from others who show empathy and mentalisation, is clear.

10.7.2 Empathy for the fellow addict on the edge

The following excerpt demonstrates Mervyn's understanding of the difficulty addicts experience regulating their emotions; from his own experience he was well aware of the vulnerability and fragility of an addict who was trying to hold himself together:

Speaking to an addict is not the easiest thing in the world, because you need to choose your words. Because if you say something wrong, it could just have a negative impact on the person and could just push him back to his drug or something, so you need to choose, you need to be compassionate, you need to understand the situation and you need to say the words they would like to hear to make them feel comfortable. You have to be very careful what you say to an addict because an addict's brain can just [clicks fingers] *switch.*

This thoughtful description of assisting addicts in need reveals the sensitivity of the addict and demonstrates how important it is to mentalise and empathise with them in order to soothe them and bring them to a place where they can open themselves to an option other than relapse, as a solution to the intense uncomfortable immediacy of their feelings. Mervyn unpacked the emotional and cognitive strategies used in order to do this, also showing how far he had come in his recovery to be able to demonstrate this and not act out and reach for his substance of choice. It can be seen how someone struggling with cravings or who is unable to contain difficult emotions would feel confidence in someone who responds in this way, from his own learning in recovery. Mervyn was, on the one hand, in it with the addict, empathising from his own experience; on the other hand, he was further along the road and able to assist.

10.8 CONCLUSION

The experience of feeling accepted, belonging and understood comes about in the context of a recovery group, as facilitators and old-timers empathise and mentalise with members who are starting out on their journey of recovery. Empathy with the experience of being uncomfortable within oneself, or the feeling that one is missing a part of oneself — which may a driver of the craving which addicts experience — is particularly powerful for those in recovery. The empathy of group members helps to normalise the chaotic and uncontainable feelings a new member may be experiencing; as he makes meaningful connections to others through experiencing their empathy, he is 'brought into the fold'.

Deficits in empathy and mentalisation are linked to problems with emotional regulation, and to addiction, in the literature. Regular attendance at the group allows the newcomer to experience positive mirroring and internalise new knowledge, understandings, ways of coping with feelings differently and new skills. This comes about via connection and relationship with others. The work of recovery in a group is thus predicated on empathy. Mentalisation is critical in terms of being able to see that other people exist in the world and to overcome the self-centredness characteristic of addictive behaviour.

The next chapter — which is the final chapter dealing with findings on psychological transformation in addiction recovery — looks at self-esteem and self-worth. Self-esteem is a capacity that emerges from early relationship and develops within the individual through internalising the responses of his caregiver(s). It is linked to addiction and recovery, as it motivates action positively or negatively, depending on whether it is high or low, and part of the process of recovery is to strengthen this. Because self-esteem originates from the response of others, the process of internalising the responses of others in the recovery group is a key aspect of the building of self-esteem and the transformation of the addict.

CHAPTER 11
PSYCHOLOGICAL MECHANISMS: THE ROLE OF SELF-ESTEEM IN ADDICTION AND RECOVERY

11.1 INTRODUCTION

The previous chapter explored key mechanisms in the recovery group which assist the cultivation of empathy and mentalisation that are essential to the recovery and transformation of the addict's identity, and represent an important feature of the addict's social learning during recovery.

Another element which some of the participants in this study identified as critical to their recoveries was the concept of self-esteem. This chapter explores the link between self-esteem and addiction, and the mechanisms by which the recovery group helped members to rebuild their self-esteem as part of their journeys of recovery.

11.2 UNDERSTANDING SELF-ESTEEM

The term 'self-esteem' was introduced by William James in 1890 and has appeared in the title of over 30 000 publications since that time (Mruk & Skelly, 2017). It is considered a key concept in many disciplines, including psychology, education, psychiatry, nursing and social work, as well as having made its way into common speech.

Self-esteem specifies the emotional and evaluative component of the self-concept (Leary & Baumeister, 2000). Self-esteem has been defined as a construct, which refers to a person's overall appraisal of their worth (Rosenberg, 1965). Self-esteem can be enhanced by using a variety of methods (Robins et al., 2012). High self-esteem has been found to predict success in life areas such as relationships, work and health (Orth & Robins, 2014). This is salient to the recovery group. In addition, self-esteem is linked to various positive psychological outcomes, including adjustment, positive emotion and prosocial behaviour (Leary & MacDonald, 2003). These are significant for the recovery group and the personal growth of its participants.

Lingiardi and McWilliams (2017, p. 99) posited that "[h]igh self-esteem develops as experiences of well-being, self-respect, vitality and reliable self-esteem are internalised in early childhood". Low self-esteem would be the converse. Ethicist Dale Ryan (1983) proposed that high self-esteem originates in unconditional love of self and is similar to humility, whereas low self-esteem, rooted in the experience of failure and in conditional love, is similar to arrogance. He found that those with high self-esteem were able to express qualities such as empathy, contentment, honesty, courage and grace, whereas those with low self-esteem exhibited self-absorption, anxiety, dishonesty and fear. Overly high self-esteem can lead to egotistical behaviour, feelings of superiority and violence (Baumeister et al., 1996). This can be tempered by empathy and mentalisation. Optimal self-esteem is a balance between not unrealistically high or unreliably low, where one feels that one is "good enough" (Lingiardi & McWilliams, 2017, p. 99). Self-esteem is a component of a sense of agency (Lingiardi & McWilliams, 2017).

Carl Rogers (1951) considered self-esteem an essential element for healthy human growth and development. For Abraham Maslow (1954), self-esteem is considered a basic human need which is closely linked to motivation and human development; he placed it just before self-actualisation in his hierarchy of needs. Self-esteem is considered by humanistic psychologists to play a vital role in the growth, well-being and self-actualisation of the human being (Mruk & Skelly, 2017).

11.3 SELF-ESTEEM AND ADDICTION

It is not surprising, then, that correlations have been found between low self-esteem and addictive behaviour. In one study, heroin addicts were found to have low self-esteem (Manganiello, 1978). A number of studies have found that those with low self-esteem were more likely to become Internet addicts (Naseri et al., 2015; Niemz et al., 2005; Sevelko et al., 2018). Among an adolescent population, it was found that there was a link between self-esteem and smoking and illegal drug use (Khajehdaluee et al., 2013). In another study, low self-esteem was found to be one of the factors associated with exercise dependence (Bamber et al., 2000). Increasing self-esteem is thus key to protect those vulnerable to addiction (Alavi, 2011; Khajehdaluee et al., 2013).

The present study revealed links between low self-esteem and poor life choices. Bob, one of the study participants, described the following experience:

> *I've met a new lady who I am going to marry, but we had a breakup over the Easter weekend. I honestly felt that I wasn't worthy of her. And she kept on saying to me, "You're pushing me away." I said, "I am doing that before you realise that I am not worthy of you and you are going to just move on, and I am going to get heartbroken." I broke up, moved out, and ended up in hospital with a suspected heart attack. My low self-esteem caused all the problems.*

This example illustrates how low self-esteem, and its associated cognitions, leads to self-destructive behaviour.

Bob described his drinking behaviour as follows:

> *I like spending money. And the others like drinking it. And I was way too easy with my money when I was drinking. I'd rather buy people drinks than have them buy me drinks. I don't know why; maybe I thought that if I buy them drinks, they are probably going to be my friends.*

Bob's low self-esteem is revealed in his description. Firstly, by noting that he bought others drinks possibly to secure their friendship, he suggests that he did not believe people would find him worthy of friendship on his own merits. Secondly, his preference for buying drinks for others rather than allowing others to buy him drinks suggests he did not feel worthy of being bought a drink. The feeling of low self-esteem is hard to bear and the role which alcohol can play to anaesthetise this painful feeling is obvious.

11.4 SELF-ESTEEM AND SHAME

Shame has been linked to issues of low self-esteem. Various studies have shown relationships between low self-esteem and emotions such as guilt and shame (Garofalo, 2015; Marshall et al., 2009; Velotti et al., 2017).

Mervyn, a participant in this study, often avoided situations and withdrew from life when he was drunk. He described this experience (discussed in more detail in Chapter 7 and Chapter 12):

> *When I was drinking, you would always shy away from a lot of things because you do not want to have a confrontation because maybe your breath was smelling of alcohol.*

Mervyn's self-consciousness when he was drinking may have triggered his low self-esteem, causing him to embarrass himself and feel ashamed.

11.5 BUILDING SELF-ESTEEM

It has been found that a person's quality of life improves during addiction treatment as the individual strengthens personality traits such as internal locus of control and self-esteem (Heidari & Ghodusi, 2016). These are two of four core self-evaluation dimensions along with neuroticism and self-efficacy (Judge et al., 1998). These should be taken into account by those working with patients in inpatient settings towards their creating a better quality of life (Heidari & Ghodusi, 2016).

Increasing one's self-worth and feeling able to contribute to society were two experiences which participants in this study reported helped to increase their self-esteem. Studies have found both of these to be essential elements of successful recovery (Prangley et al., 2018).

11.5.1 Affirmation of worth as a foundation for self-esteem

In the following excerpt, Karen describes having experienced a sense of gratitude and humility early in her recovery as she began to open up to receive from the world around her, even simply as being acknowledged as another human being:

> *Most addicts will tell you: when we leave here, we don't know what we need. We don't know what we're not getting if we don't know what it is we're supposed to be getting. That's why we're grateful for anything we get. The fact that you people give us that means more to us than you'll ever know. From the security guard who*

smiles at us and greets me by name — that's what is important: we're people. And we've only ever known what we wanted — not what we needed. So anything we get given we are grateful for.

Mellony Graven (2004), using a communities of practice framework based on Wenger's (1998b) work, looked at the practice of becoming a mathematics teacher (over two years) and described how confidence is built up and facilitated, as a product and a process, in the overall mastery of becoming and being. This resonates with Forcehimes and Tonigen's (2008) study which found that the confidence to remain abstinent has been identified as a mechanism explaining behaviour change in mutual-aid research.

Karen speaks about how those who share confidently have the power in the group because they have the length of experience and know what they are talking about. She says how the most important thing she has learnt in order to recover has been self-worth.

For Bob, realising and building his self-worth came about through numerous actions:

Being in the clinic again helped me realise that I am worthy; that I am not a piece of shit on the side of the road; and I am worthy of L's love and that I am a good person. Listening to other people's problems helped me realise that my life is not that bad, that I am not that bad, and that it's not that bad. Talking to the psychiatrist and psychologist and realising that I am worthy, I really am.

To begin to matter again, in a positive way, to others begins the process of being able to see oneself as having value as a person.

11.5.2 Behaviour as a foundation for self-esteem

For psychodynamic writer Nancy McWilliams, a reliably based self-esteem is considered a characteristic of psychological wellness (Linguiardi & McWilliams, 2017). Self-esteem is based on the achievement of goals and behaviour, and is the individual's subjective assessment of their own worth that encompasses both beliefs and emotional responses to the self. We see this in Bob's description of his assessment of himself and of his behaviour as he slowly built his self-esteem during recovery:

Also that I have recovered for one year, seven months and three days and that has contributed to building my self-esteem. And I don't have to wake up embarrassed, with low self-esteem; with people thinking how bad I am — thinking I'm just a rubbish.

Bob's description exemplifies the steps involved in building self-esteem, which he learned on his path to recovery. He actively engaged with the recovery process emotionally, cognitively and physically, listing the various activities that impacted positively on his self-esteem. He went back to the clinic to get help, recognising that he needed it. There, he attended classes where his negative assessment of himself was challenged; he opened himself up to listening to the others' difficulties and, in so doing, stopped pitying himself. He consulted a psychologist and psychiatrist regularly. All of this culminated in the fact that he was sober at the time of the interview, for over nineteen months, and that was something of which to be proud. He had something tangible and reliable on which to base the assessment of his self-worth.

Karen explained how her self-esteem developed through assisting others in the group:

Making a difference to others motivates me. I want to have them hear me talk about myself, and give them motivation to stay sober.

The more Karen believed she was helping others, the better she felt about herself and the more motivated she was in continuing her recovery.

Mervyn described how the poor self-esteem he had experienced when drinking changed into a sense of pride when he stopped drinking:

I've got better self-esteem, more confidence ... the mind is clear, the eyes are right, the breath is okay: so you can go head-on into a situation and you're thinking clearly, you're thinking rationally, you maintain your integrity.

This was echoed by Bob:

When I first came here, I wasn't sure I could stay sober, but now I feel really good that I am sober. I feel extremely proud of myself that I am almost two years and to actually achieve that. I'm so confident now that I can go to the bottle store for

my fiancée on the odd occasion that she drinks. It's a relief. It makes me walk up straighter and be very impressed with myself.

Building self-esteem is an active process comprised, in the case of the recovery group participants, of setting goals and taking actions to reach them, and is accomplished over time. This gives the person tangible proof of their worth that challenges their previous negative self-assessments.

11.6 CONCLUSION

This chapter has explored the role of self-esteem as a critical component in addiction and recovery. Similar to the cycle of shame and addiction discussed earlier, a low self-esteem contributes toward regrettable choices and behaviours, which further reduce the addict's negative evaluation of herself, thus becoming a self-fulfilling prophecy which perpetuates a downward spiral. Part of recovery is then drawing a line and making a decision to recover; then beginning to build oneself up consistently, through listening and learning from others, setting personal goals and achieving them, self-reflection, conscious decision-making and action over time.

11.7 CONCLUSION TO THE PSYCHOLOGICAL ASPECTS OF TRANSFORMATION (CHAPTERS 7–11)

The previous five chapters have explored the findings that emerged revealing the psychological transformation which participants experienced as members of a recovery group, and have highlighted many of the group mechanisms that emerged which facilitated this transformation. Several aspects of psychological transformation emerged which needed to be addressed in recovery: the key emotions of shame (Chapter 7) and anger (Chapter 8); the importance of breaking denial in order to re-establish honesty in the recovery process (Chapter 9); and the building of the capacities of empathy and mentalisation (Chapter 10) and self-esteem (Chapter 11), and their role in recovery. These aspects of psychological transformation rely on different ways of relating with other participants for their effect on the recovery of the addict. Chapters 7 to 11 have attempted to explain how they emerged and were understood and worked with in the group, resulting

in the transformation of the participants in recovery. Aspects of social learning and psychological theory have been noted where relevant.

The next chapter explores the physical aspects of the addict's transformation.

CHAPTER 12
PHYSICAL TRANSFORMATION FROM ADDICTION TO RECOVERY

La Belle Dame Sans Merci
(the beautiful lady without mercy)

"Ah, what can ail thee, wretched knight,
Alone and palely loitering;
The sedge is withered from the lake,
And no birds sing.

. . .

I see a lily on thy brow,
With anguish moist and fever dew;
And on thy cheek a fading rose
Fast withereth too.

I met a lady in the meads
Full beautiful, a faery's child;
Her hair was long, her foot was light,
And her eyes were wild.

. . .

She found me roots of relish sweet,
And honey wild, and manna dew;
And sure in language strange she said,
I love thee true.

. . .

And there we slumbered on the moss,
And there I dreamed, ah woe betide,
The latest dream I ever dreamed
On the cold hill side.

I saw pale kings, and princes too,
Pale warriors, death-pale were they all;
Who cried—"La belle Dame sans merci
Hath thee in thrall!"

I saw their starved lips in the gloam
With horrid warning gaped wide,
And I awoke, and found me here
On the cold hill side."

—John Keats (1795–1821),
The Poetical Works of John Keats (1884)

12.1 INTRODUCTION

This study found that the transformation of the identity of the addict involves key aspects of the self: spiritual, psychological and physical. The previous chapters in this section have explored the findings in this study which related to spiritual and psychological transformation. This chapter explores findings related to the physical aspects of recovery.

An addict's experience of cravings and relief is primarily physical. Recovery involves learning to tolerate and manage these physical feelings in the body differently — without turning to one's substance of choice.

This chapter explores the embodied experience of the addict as she engages with herself and the world and the changes which may occur in the body, the lived-world and the behaviour of the addict in the journey from addiction to recovery. The pedagogical mechanisms that participants identified in the recovery group which related to these physical aspects of addiction and recovery are examined.

12.2 PHYSICAL ASPECTS OF ADDICTION

It is important to understand the bleak, destructive physical world of the addict in order to appreciate the gratitude the addict in recovery experiences when he regains even minor aspects of a normal physical life. Mervyn, for example, experienced relief that his gag reflex was no longer stimulated every day when he brushed his teeth:

> *Every morning I am so happy: I can put my toothbrush in my mouth without any hesitation. Little things that mean a lot.*

The tyranny of addiction is often experienced in intensely physical ways.

The research participants described the physicality of withdrawal from their addictive substance (in this case, alcohol), culminating in a hangover, where typical symptoms included headache, fatigue, inability to concentrate, upset stomach, sweating, anxiety, irritability, general malaise, as well as loss of appetite. The research participants often used the South African slang word *babelas* for a hangover.

Mervyn described his experience:

It had gotten to a stage where I would drink after work. I would get to work feeling babelased and feeling sick and I would wait till after work to have a drink. Then it became more serious, when I would drink in the afternoons. And sometimes in the mornings I would have a drink at work in order to sort the babelas out. So my drinking actually spiralled very seriously out of control.

This experience was echoed by Zimo:

When I went to work on a Monday, after work I would drink. Then it escalated whereby you think you are putting off the babelas for Monday, but you are putting in the babelas. So on Tuesday, you want to take off the Monday babelas, and so it ended up becoming a daily thing.

The domination of the addiction over the addict is clear in these quotes, highlighting the destructive nature of addiction and the attempts by the addict to defer the physical suffering of the eventual hangover.

Addiction affects the addict's self-perception and way of being with others. Participants described how, while under the influence, they were aware that their physical presence was affected and that this influenced their social behaviour. Mervyn described his awareness that he looked and acted differently because of the effects of intoxication:

When I was drinking, you would always shy away from a lot of things because you do not want to have a confrontation — because maybe your breath was smelling of alcohol, maybe your eyes are bloodshot, or your speech is slurred — so you would not want a confrontation.

Mervyn explained that when under the influence he wanted to avoid interaction not only because of the possible shame of being found out, but also because of the pounding headache that left him feeling too unwell to interact with others:

You see, if you're at work and your head is sore, you just want to shy away from everybody. You'd give reasons why you will chat to them tomorrow, or cut the conversation short. Even if it's an argument, you just say, "Yes, yes, yes, yes," just to get the person off your back. So you would not relate your part as such. You would just shy away from it as there are other reasons why you don't need

this argument or don't need this confrontation — it's because your head is sore, or you need a drink or whatever.

Due to the unpleasant physical experience of addiction, the addict may thus intentionally reduce his relating with others, adding to his isolation.

Stephen's story of the final stages of addiction is typical:

In the end my addiction spiralled completely out of control … I would wake up in the mornings a nervous, shivering, almost psychotic wreck and I would lie in bed and wish I would die. But I didn't die. Then I would slowly start eating — 'cause I didn't eat. After a six-day binge I would wake up and try and recollect what I had eaten and have a vague recollection of a packet of Simba chips somewhere, or a bite of somebody's pie somewhere else, which you couldn't stomach. Then I would spend five or six days recovering in bed, telling myself I had to stop this and really believe myself — that I was going to die. But then, somehow, the moment I started feeling ok again … then I would think, "Ok, let's go and have a drink — but this time I will do it differently: this time I won't let it get out of hand." Famous last words; because it always did. And I would repeat these five/six day binges over and over again: doing the same thing; expecting a different result.

Stephen's description of the wretched physical state brought about by addiction is vivid: the shivering, hungry, nauseous physical state of being in a world coloured by self-deception, anxiety, depression and futility; the addict is trapped in the tragic cycle of addiction until something changes or breaks.

Even for those with diagnosed illnesses, where they knew that using the substance of choice would be detrimental to them, the addiction overrode everything.

Bob talked about his diabetes*:*

When I was diagnosed with diabetes, I didn't touch anything [alcoholic] *for six months. And then I started drinking again. … I ended up in hospital because my sugar went sky high. I was hallucinating. It happened on a couple of occasions because of my sugar and the alcohol. But I still carried on drinking.*

Peter, who has epilepsy, commented on his addiction to cocaine:

> *I also passed out, but not from cocaine. ... I'm vulnerable to seizures — because of a head injury — which the cocaine was bringing on. ... While I was sniffing, I was having more seizures, more frequently. And when the story came out of me using coke, that's the first thing they put it down to — the use of coke. But that was minor — I'm not too worried about myself.*

Peter's prioritisation of the substance of choice over any self-care or rational decision-making regarding healthcare is evident in his description.

The same theme is evident in Boet's words*:*

> *I actually landed in hospital because of it. I realised that I was overdoing it. I realised that unless I stopped ...*

His words implied that if he did not stop, he would end up dead. This was common in many of the participants' accounts.

In active addiction, addicts adopt a way of life where their world becomes truncated as their lives revolve increasingly around the substance of choice. People and experiences are eschewed, as are significant health concerns: all that matters is obtaining the substance of choice. As this happens, the addict becomes increasingly isolated and withdrawn. This is also typically accompanied by physical decline, as shown in the excerpts above.

Stephen commented:

> *I remember being stopped by someone who used to know me who said how thin I was. He asked: "If you can get money to get out of it, why can't you get food?" And I remember saying, "Because you can go and sit in a Wimpy Bar or a Steers or Spur all day and not one soul will offer you a plate of food, but if you go sit in a bar, somebody will offer you a drink." That's the difference. It's easy to get the drink; it's hard to get the food.*

But the addict's first choice is the substance of his addiction. Despite such difficult experiences arising from addiction, a person who is addicted will typically continue in this way of existence.

12.2.1 The lived space of addiction

According to Kemp (2011), addiction increasingly narrows the breadth of the addict's life as he progressively withdraws from the world, focusing only on his substance of choice. This can be seen in the addict's limited routines in terms of both his physical behaviour and the space he occupies in the world. In fact, addicts withdraw from the world:

Zimo described his experience of this narrowing and downward spiral:

> *As time passed, there was not so much money to spend. So when the money was finished, I would go and borrow money: take out loans — loan sharks. Then that became a problem. So then, to drown your sorrows, you go to drink. Then it all just got worse and worse and worse and worse. And it became a daily thing, and became part and parcel of my life. And everyone knew "Zimo is an alcoholic". They knew at home; even at work they knew: If he's not coming he's probably babelased. It became a routine to me.*

Nikhil's experience was similar:

> *I was the biggest drinker of my friends: binge-drinking seven days a week, no eating, no sleeping, drinking continuously. In the end, it was a continuous circle: it started with a binge, it ended the same way. And the following week: it started the same way, it ended the same way.*

The bleak, destructive, repetitious entrapment that comes with addiction is clear in the lived lives of these participants.

Kemp (2011) writes that addicts often reduce their lived space to their homes, or even a specific chair or piece of furniture, thus constricting their existence further. He describes how the addict sticks to specific routines and pathways because, in order to cope, his world needs to be manageable, predictable and limited. The ambiguity and complexity of the world and its myriad possibilities are reduced or ignored.

This is illustrated in Mervyn's experience of going on holiday to the beach to visit his brother — a situation which abounded with possibilities:

I got up on my own, went to his garage where he had a fridge of alcohol, and I'd drink. And I'd drink the whole day through: go to the beach, do whatever, and drink. Get up in the morning and drink.

This highlights the fact that, irrespective of the setting, the addict will repeat their addictive behaviour and routine regardless. Nowhere does Mervyn describe enjoying spending time at the beach or with his brother, whom he had gone to visit — because this did not happen: in his intoxicated state he did "whatever" — everything else did not exist for him. Even though the addict may be with others, inside himself he has withdrawn and cut himself off from authentic human relationship.

The addict becomes entirely focused on obtaining her substance of choice. All emotions are concentrated on this — obtaining, using and the after-effects of the substance — and are thus reduced to a narrow way of existing.

Alexis had been going through a challenging time and had booked herself into a psychiatric facility to give herself the opportunity to work through her issues. In the following quote, one can see her addictive thinking in the way she compressed everything into begging for her substance of choice, rather than opening up to the opportunity to work through her issues:

I was getting bad last week. All I kept thinking about was my pills. And when I got admitted, all I wanted was my pills. And I wanted them at the time that I wanted them. And I said to the sister, "Give me my tablets! Give me my pills! Please: I need my tablets!"

Here we see how meaning is converted solely to obtaining the substance of choice; the world, and the addict's participation in it, becomes reduced to obtaining the addictive substance, and little else.

12.2.2 Lived-body, thing-body

Kemp (2009) describes the body being constantly at the forefront of the addict's experience. The addict is continually aware of her body, through either the relief or pleasure of the effect of the substance of choice, or the suffering that she experiences

before or after obtaining the substance. The calls of the body for the substance of choice are louder than anything else. The body of the addict thus becomes the locus and focus of much of the addiction. It ceases to be experienced as a 'lived-body', where the body is used for its own sake and to enable the person to experience the world, and instead becomes to the addict a 'thing-body'.

122.3 The physical 'tipping point'

While each addict's experience of finally deciding to stop is unique, there are some common patterns in the way addicts typically come to give up and enter recovery. There is the dramatic 'hitting rock bottom' — where the addict has lost everything, and the next step is either death or recovery. There is also the experience of 'being sick and tired of being sick and tired'.

In addition to various other reasons the addict might decide to stop, there appears to be a physical aspect to this life-changing decision, irrespective of the substances of choice. In many cases, participants began to feel so physically horrible that they could no longer face it; others reached the point where they actually faced death.

Mervyn described his experience as follows:

> *The next morning, I woke up feeling terrible, terrible, terrible: your hands are shaking, you put your toothbrush in your mouth and it's very uncomfortable — you want to vomit everything out. So I sat and I thought about it. And I thought, "No, I really need to get some help."*

For Mervyn, the light bulb moment was through his bodily experience — realising that he did not want to feel like that any longer. For Peter, it was the way his addiction took over his lived space:

> *When I realised I had a problem that needed fixing is when it filled my thoughts all the whole time. Secondly, I would leave some at home and then I'd make excuses to go and fetch it. I'd think that I'd keep some for tonight when I got home from work or whatever, but I couldn't do that. I had to climb in my car and make some excuse to go and pick it up. Then I realised that something was not right.*

And that I've got a problem — when it filled all my thoughts and consumed me. I'd think the whole day, "Ooh, a line would be good now."

Peter's mental and physical life was dominated with planning where his next fix was coming from. His entire being was consumed by his addiction. Vega's experience resonated with Peter's:

I had no idea I had a problem. And then obviously once it got worse and worse and you're starting to have to lie, make up excuses to go and get more. And your whole day is [spent] working out how you are going to go and get the next fix. You're scheming. ... The penny dropped when I realised I couldn't stop. It's the weirdest thing. It just doesn't occur to you that you have a problem, but when I was having to start lying, start making excuses why I had to go out quickly at night — "Just have to go to the shop quickly" — meanwhile I am racing to the chemist, I realised I had a problem because of the things that I was doing. I realised I had a problem now but I couldn't stop. Doing all these things to go and get the stuff, and I realised this is not right: something is wrong here. Then I thought, "Let me try and stop. I need to stop." And I couldn't. I tried on my own, first, and that's when it occurred to me, when I couldn't stop, that I had to keep going and feeding this thing: that I couldn't stop because of all the withdrawals.

Here, again, the dominance of the addiction is clear, not only over the life-world of the addict, but over her relationship with herself and others, culminating in the terrible realisation that she was unable to stop her addiction because she was unable to withstand the physical withdrawals on her own and it held her totally in thrall.

Vega's story culminated in her addiction taking her to the door of death:

I passed out. And in the process of passing out, I hit my head on the corner of the wall. I was concussed and I woke up in a pool of blood. My hair was in a pool of blood because I had cut my head open. And so on that occasion I realised that I nearly died. I could have died. And the penny dropped: I needed help.

Here a serious, physically embodied experience shattered her denial with the realisation that her addiction had nearly cost her life.

Alexis's tipping point also involved a destructive, physically embodied, eye-opening experience in which she embarrassed herself publicly, after falling and being hospitalised in front of her nursing colleagues:

> *I fell at home because I'd taken too much of the medication and had a blackout. I didn't know what was going on. And then when I got to the clinic, being told I had a problem there was no choice in the matter — that I had fallen onto the floor* [again at the clinic] *and I couldn't get up off the floor, and the girls* [fellow-nurses] *had to try and pick me up. And I realised now that there is a problem because now all of a sudden I wasn't getting the medication and the doctor has given me other stuff that's not working and now I'm crawling around on the floor trying to find the emergency bell to ring to get the girls to come and help me get off the floor. So then I thought that there must be a problem somewhere. I was embarrassed 'cause the girls couldn't get me off the floor. And the feeling of shame, because they couldn't get me off the floor and people had to see me. And getting up was my job and now I was relying on other people to do what I would normally be doing. So it was embarrassment.*

Here Alexis linked a physical experience with public humiliation and this broke through her denial sufficiently for her to realise she needed help. For both Alexis and Vega, a personal line was crossed which allowed them to see what addiction was doing to them.

Nikhil described his physical tipping point as follows:

> *I realised that the lifestyle that I was leading wasn't conducive to me. There was something wrong with me — with my behaviour — because every week was the same and you stop where you started and you carry on. And my body wasn't coping; my family wasn't coping: everything around me was falling.*

Here not only was his body degenerating, but he saw that every aspect of his life was starting to fall apart because of the way he was choosing to live and something needed to change.

The physical aspects of addiction thus can be extreme: the agony of the physical body reduced to a thing, compelled to get its fix; the anguished mind, enslaved to the tyranny of addiction in the endless task of obtaining the substance of choice, which brings only

temporary respite. In addition, the very real prospect of paying the ultimate price for addiction: one's life. Yet it is frequently these physical aspects of addiction that finally bring the addict to the point of change. Understanding the physical nature of addiction is thus crucial to understanding recovery. For those who embark on the journey of recovery and enter rehabilitation, however, the road that lies ahead of them is not easy either.

12.2.4 The physical experience of 'rehab'

Once the step has been taken to enter rehabilitation, a new path begins. It is initially difficult for the addict who, despite being prescribed various medications to ease his withdrawals, is in a new environment without access to his substance of choice. This can be terrifying.

Mervyn described the first part of the recovery process: physical detoxification.

> *The first night was a very terrible night. I slept alone in a room. … I never slept. As the alcohol weared out of the body, you're lying in an unfamiliar room, trying to sleep. Then the DTs* [delirium tremens] *start to set in, where you are getting cold sweats, you are getting bad dreams, and when you wake up, you wake up in a fright — you know, in different surroundings. So for that whole night, I basically never slept.*
>
> *After that my psychiatrist ordered me some medication to help me sleep. But I was feeling very sick. Sick in the way that the alcohol was coming out of your body and you cannot put a single piece of food in your mouth. I think it was for a week where I had no appetite. I could not eat. It was a terrible week for me.*

McKenzie similarly found the initial physical withdrawal from the substance of choice an intensely physical experience:

> *Two days into this place — going through DTs, confusion, seeing things, sweating, without alcohol — I realised that I had the problem of alcohol. Because alcohol blurs everything, but once you sober up you start getting the shakes — the DTs and that.*

The physical nature of addiction, which often brings the addict to the point of change, continues to cause agony as the addict begins the process of recovery. While the addict courts death while engaging in addictive behaviour, after choosing sobriety, death remains a very real risk as the substance is withdrawn from the body.

12.3 THE PEDAGOGY AND PHYSICAL MECHANISMS OF RECOVERY

> *If, over a three-month period, in that three months if you stay clean, a few things happen. Firstly, the body of the addict is healing. The body is experiencing recovery. By three months, the body is in a much better state than ever. — Rio, addiction counsellor*

This section looks at how one teaches recovery, with a focus on the physical aspects. Neuroscientist Antonio Damasio's notion of consciousness as the explicit link between the body and the mind is explored, along with the capacity for a person to learn from experience. The cultivation of different ways of working with physical symptoms as part of the pedagogy of recovery is discussed.

Here, the inpatient experience is examined through the participants discussing their experience of newcomers in the group. The section explores the aspect of the newcomer's physical presence in the group: their embodied presence as recent addicts and what that meant for those further down the road. Their physicality served as a pedagogic mechanism for themselves, the outpatients and the addiction counsellor.

12.3.1 Damasio's conception of consciousness

Recent findings in neuroscience have included identification of areas of the brain and the mechanisms accounting for the formation of self, identity and consciousness, social emotions, and empathy (Porankiewicz-Żukowska, 2017). With findings relating to the human nervous system, research has examined the relationship between psychic and physical phenomena, which links to the nature of the mind and the relationship between mind and body (Mianji, 2015). Neuroscience can be considered an approach to explain

the phenomenon of social nature (Garza & Fisher Smith, 2009). Antonio Damasio is a leading expert within this field.

A basic understanding of Damasio's (1999) conception of consciousness is useful in the context of the pedagogy of addiction recovery, as it links the physical aspects of addiction with the mental aspect of recovery. Damasio's work is included here as it takes our understanding of recovery pedagogy further.

Damasio's most significant contribution to neuroscience is arguably the notion that feelings are considered to be mental experiences of body states (Dolan, 1999) which arise as the brain interprets emotions (Pontin, 2014).

For Damasio, feelings do not cause bodily responses or symptoms, but are in fact caused by them — the physical response is primitive and primary. Here, Damasio is referred to by Eakin as he quotes William James: "We do not tremble because we feel afraid, we feel afraid because we tremble" (Eakin, 2003, para 22). This is counter-intuitive to the generally accepted understanding that we feel afraid first and then we tremble. Damasio (in Lenzen, 2005) conceives of consciousness as being based on a representation of the body and as changing in response to certain stimuli. Damasio considers that the conception of self-image would be impossible without this representation, which functions as a regulatory homeostatic organism. In order to survive, the brain constantly needs current information on the body's state to regulate the person. Damasio considers that emotions alone — without conscious bodily feelings — would **not** be enough. Adults would be lost if they suddenly lost their self-image, which is only possible through the concept of consciousness (Lenzen, 2005).

Damasio holds that there are close links between mind, body, consciousness and identity. This study has revealed how all of these are critical in the pedagogy of addiction recovery. For Damasio (1999, p. 283), the "mind is so closely shaped by the body and destined to serve it" and so the interrelationships between these aspects are essential to examine in order to understand the physical changes in the addict and concomitant changes in consciousness and identity through the recovery process — while all the time holding the group as the pedagogical context.

12.3.2 The teaching of recovery through focusing on the physical

An awareness and understanding of the physical aspects of addiction and recovery, as well as how emotions and cravings manifest in a group context, are essential in teaching recovery. One of the addiction counsellors, Dave, highlighted this by sharing some of his approach, which was also discussed in the chapter on anger. The focus here is using the body's responses to link to emotional states and then awareness. The previous focus was on dealing with anger in the present. Dave said:

> *... when I walk into a group room, I gauge who's looking out of sorts. Who's twitching a bit? and then focus on "what's going on for you? what's going on for you?" and evoking those feelings and emotions and then getting to the root of it by looking at what's happening for them now and trying to relate that to what made them feel like that in the past. What have you done with that (emotion): how have you tried to cover that up? By using?*

In Dave's mind, he has already linked observable behaviour, body posture and appearance to emotional states. He is aware he needs to make this link tangible for the addict in order *to build his consciousness and commitment to recovery.* He continues:

> *I'm very much focused on body language and posture. For me it tells a lot. Like the other day we were talking about someone in group who was on their* [prescribed] *medication and obviously loving the buzz and I could see the gentleman next to him was looking down. But down — for me — in addiction means that there is hidden anger there. And I asked the gentleman "Why are you so angry? Who are you angry at?" and he said he wasn't angry. But I saw him clench his jaw and the muscle in his cheeks go and I knew straight away he was angry because he made that response. So what it did was it opened up for him to say, "I'm angry with this person, and that person, and this other person." He wasn't angry really with the person next to him on the buzz: it triggered his own feelings.*

Examining this more closely, we can see how the newly recovering addict had his anger triggered by another group participant next to him whom he perceived as high when he was not. He did not even realise that he was angry and it took the addiction counsellor to observe and remark on his clenched jaw and tense cheek muscle and downward gaze to

allow him to connect with and own his feelings, and then open up to working with these feelings in the group.

Exploring this, Dave says:

> *One of the hardest things to try and control is the way your body acts when going through feelings. And feelings are extremely important because there are only two feelings we knew in addiction: good or terrible. And when you take the substance away you get a flood of emotions and feelings coming back and people can't even say what it is. Some people don't even know what that feeling is, so being able to explore it a bit and finally get them to put a name to it helps, because then they know that the next time, they feel jealous, "Ah, that's jealousy! I know jealousy — I know what that feeling is." And they learn to start dealing with those feelings and emotions 'cos they can put a name to it.*

Here Dave's pedagogy focuses on the belief that one cannot disguise and mask what one is feeling in a bodily sense: in other words, that the body communicates continuously. Understanding the nuances of this communication is key to widening the recovering addict's capacity for tolerating emotion — an essential technique in moving them from the narrow and bleak world of addiction and its all-or-nothing thinking of things being either good or terrible, to being slowly able to name and contain a variety of emotions. This introduces richness and flexibility to the addict's emotional repertoire and builds their self-perception and, as a result, their consciousness grows and refines. Here the link between the feelings in the body and consciousness are clear. And once one has named emotion and has awareness and insight into it, one has a way of working with it and understanding it — rather than just trying to numb or soothe it by taking substances.

12.3.3 Cravings: finding a 'new normal'

Arguably, the most significant time the addict's body makes itself known is when the addict craves — during both addiction and recovery. Succumbing to that powerful longing is what will precipitate a relapse. For this reason, working with cravings and developing a repertoire of understanding and behaviours that empower the addict to resist the craving is a critical aspect of addiction-recovery pedagogy.

Bob described the physical intensity of experiencing a craving:

> *The last time I had a craving, it took me a long time to calm down from that. It was the harshest craving I have ever had. It was at my sister's place and my fiancée opened up a beer and I think it was because it was her and because it was my drink of choice — it just fucked up my mind. The craving was so intense: I was so angry I wanted to go and grab that beer and just drink it. I've never experienced anything like that — it was so hard. Really, really hard. And it lasted for about twenty minutes. ... I walked outside, and my niece came and sat with me and tried to calm me down. I spoke to my fiancée, who said, "No," and went and threw the beer out. And after the craving had left, then I was fine — I was still pouring beer for my fiancée. It was just that initial craving when I saw her open up the first beer — I just can't explain it. I've never had a craving like that before — it was here, in my gut, it was horrible — I just wanted to just go and grab it and drink it. I was very surprised that I had the self-control not to do it. It built me up hugely and since then — and through all the shit I've been through lately — I never once thought of drinking.*

It is important to highlight here how Bob felt the craving physically in his "gut".

Zimo described how his physical craving made his body begin to shiver and shake. The intensity of his experience was also triggered by seeing someone else drink his drink of choice:

> *Me and my girlfriend were at a steakhouse. There was another guy at a table opposite ours. He was working at his laptop and he had his Heineken dumpie* [750 ml] *— extremely cold. You could see the water dripping down the side. Yo! Up until now, that feeling, I've never had it before. I can't explain it. It's like my body started shivering. I told my girlfriend, "Babe, let's move to another table." She said "Why?" I did not explain to her — I just showed her. And then she went to that guy and told him that I'm in a recovery process so I'm feeling uneasy with his drink, looking at his drink. So that's why we are moving. 'Cause he could see we were talking about him. And the guy understood. And then we moved. It took about eight minutes, 'cause now she was talking. I couldn't even hear a word she*

was saying. Even though we had moved to another table, I was still shaking. Even now I don't understand it.

Hirschman (1992) notes that recovering addicts are vulnerable to relapse during social situations in which they might have previously drunk or used drugs, and this behaviour was seen as 'normal'. Now, having stopped using the substance of choice, the recovering addict often feels socially anxious and awkward, and these emotions can trigger a craving both to relieve the anxiety and also to allow the newly recovering addict to fit into the social situation again. It is important to share these feelings and experiences in the group to make a 'new normal' and to prepare recovering addicts for the possibility of this occurring.

Bob described the role of the group in helping a person to resist cravings:

You can come here having such bad cravings and you've got people to talk, because they've been though the same thing as you. And you know they are talking sense. And it triggers something in your mind and you think, "No, [I] don't need it. He's been through it: I can do it too."

Knowing that he is not the only one, and having contact with others who have been in the same difficult situation, gives hope and courage to the addict through his time of craving.

Dave, an addiction counsellor, commented on the role of hope:

Hope is important because it allows you to get through that day — and hopefully get through the next day. Group therapy is very intense — a lot of feelings are evoked. So if they can get through that day with all those feelings, and wake up the next morning knowing, "I didn't use yesterday even though I felt like crap: then maybe there is a chance that I can do this."

Here we see how the capacity to tolerate difficult emotions is cultivated — because the typical response for the addict would be to not want to feel those feelings and use.

12.3.4 Cravings: 'Playing the tape forward'

Knowing that the moment of truth for any addict is having to deal with cravings, Dave prepared group members for managing them without relapsing — a crucial aspect of the teaching of recovery.

> *So, I provoke a craving and then start getting them to play the tape forward: where is this going to end up? Where is it going to end up? I do that because with every craving that comes up for an addict, it only shows the good times. It will never ever let you see that it made you steal money from your mom's handbag, left you in the gutter, or left you in a jail cell. It will only show you that, "Ooh this is how it made me feel — it made me feel so good," and remember when I had a load of money back in 1996 — all that stuff. So being able to say, "Ok, great, it sounds good. If you use it, what then?" "Well then I'll probably have another one." "Ok, then what? And then what and then what and then what?" And then what you find is that they end up taking themselves to the place where they are right now: "I'll be in a treatment centre and my life in a wreck."*

'Playing the tape forward' is a tool to help work with cravings. Dave triggers the initial cravings — allowing the addict to indulge in the reverie of the intoxication — before then applying her rational mind and its knowledge and experience of consequences to what would happen should she use again. This technique is valuable in creating a new 'tape' that serves as a template, which is now played until the final consequence — and does not stay stuck, as it previously did, in the imagined delights of intoxication. There are echoes of Keats's poem *La Belle Dame Sans Merci* here where, after the seduction by the beautiful maiden, the knight wakes starving, cold and in a bleak land with others who have fallen prey to her — a perfect analogy for addiction. 'Playing the tape forward' serves to expand the conscious awareness of the addict by facing the consequences of using before they possibly do. The connection between the feelings of craving in the body and mind, and the consequences of using are made explicit here.

12.3.5 Guarding against triggers

The twelve-step programme looks at managing cravings in terms of the triggers **h**unger, **a**nger, **l**oneliness, and **t**iredness (HALT). Newly recovering addicts are initially unable to distinguish different bodily sensations and use drugs as a remedy for all of these four triggers. In the recovery group we added B for **b**oredom and I for **i**ntense emotion — people have been known to relapse during a celebration, so to be mindful of intensity of any emotion. In addition, the twelve-step programme teaches to be on the lookout for 'PPP': **people** one used with; **places** one used in; and **playthings** associated with one's addiction. These are all potential triggers of craving. In the examples above, both participants were triggered by seeing their substance of choice, which is an obvious and typical trigger.

Another strategy for avoiding a trigger is to stop driving one's usual route which passes the merchant or bottle store where one used to purchase one's substance of choice. Or if one drank vodka and orange juice, a strategy would be to avoid orange juice as it could trigger a vodka craving. For Karen, a trigger was holding a hundred rand note, as it was what she used to roll to sniff cocaine. Vigilance of one's physical environment and awareness of oneself is critical in managing triggers which could lead to cravings.

A task given to recovering addicts is to try a range of different milkshakes and see which their favourite is. This exercise reconnects the addict to her body as most addicts would not have had a milkshake in years. It also encourages addicts to go to a place they would not associate with their addiction and open themselves up to the world a little.

12.3.6 The pedagogical role of inpatients in the physical aspect of addiction recovery

Inpatients at the clinic who attended the recovery group as part of their rehabilitations were in the beginning stages of the process of learning to recover from addiction. They played a very important role in the recovery group by reminding those addicts further down the road of recovery of where they had come from. The presence of inpatients in the group is therefore a vital aspect of the pedagogic process.

Mervyn, one of the outpatient participants in the study, commented on this:

> *My motivation comes from the inpatients, because when I see one suffering — holding his stomach, all gaga'd — you see what the inpatients are going through and that is an eye-opener as to what is going to happen to you if you relapse: you gonna come back looking like them. And I don't want to do that — because they are suffering. I suffered through my initial stages of recovery and I do not want to go back. I still do get the cravings. I still get those 'of the blues' moods — but by looking at the inpatients it strengthens me: it takes me back to my basics.*

Mervyn's comment demonstrates that the mere physical presence of inpatients in the recovery group served as a touchstone for those who were further along in their recoveries, motivating them to continue with their recoveries as they were reminded of how difficult the experience of beginning recovery had been and how far they have come. This view was echoed by Scott, who spoke passionately:

> *Thank God it's not me — thank God I am over the condition that they are still in, in early recovery!*

Spero commented on the anxiety that was evident among the inpatients in the recovery group:

> *I feel desperately sorry for the inpatients. I see how fidgety they are. They are scared to leave* [be discharged].

Vega added to this observation:

> *It almost seemed like they are disinterested, but what was happening was that they were struggling with what was going on with everything inside them. It's almost as if they weren't quite in the meeting but I think it's what they were going through. I didn't get the feeling from all of them, but there was a strong feeling of "I have to be here." But for some it's like just trying to hang in there.*

The outpatients related to the world of those new to recovery — the anxiety, feelings of being lost, or confused; for some, resignation; for others, just surviving each moment away from their substance of choice. They saw the newcomers' physical suffering and remembered their own. The empathy they expressed indicates how far they had come in their own recoveries. While during addiction the addict is obsessed and consumed by

themselves and their own needs, these comments by participants revealed that they had begun to look beyond themselves and actually see others with compassion.

12.3.7 Noting physical appearance as a recovery pedagogy

The inpatients in the recovery group reminded the outpatients of where they started off — haggard, bleak, suffering and ill. The outpatients served to remind each other of how far they had come and how well they were doing by making positive comments about the others' appearances. Participants responded with pride when others commented on their improving appearance and health. Here is an example of one such interaction:

> *Dave: You're looking happier and so much better.*
> *Alexis: I'm still in lock up! [in a general psychiatric clinic] [laughs]*
> *Vega: She's really looking a whole lot better.*
> *Alexis: [Beams at the group happily and shyly].*

Previously, participants had commented on the fact that when Alexis first joined the group she hid under her crocheted poncho, clutching her large handbag on her lap as if to hide behind that too. Over a year later, she was placing her handbag on the floor, wearing short-sleeved tops and shorts and sitting with an open posture.

The positive effects of recovery on an addict's physical appearance were shown too in Rio's account of not recognising an addict he had worked with:

> *There's been a Whoonga* [a cheap street drug available in townships] *addict I've watched physically change and I could not recognise the person. I hadn't seen him for about a month and was waiting to pick him up and was looking around and then he came to the car. He had shaved, his skin colour was lighter, he looked different, and he said that for two months he hadn't used Whoonga.*

Rio unpacked his surprise further:

> *Now that, to me, is inspiring because there is no replacement programme for that drug yet here* [in South Africa]. *He's just coming to meetings; he doesn't have a phone — someone else communicates on his behalf; he's not working; he's staying*

in the environment with all the other guys who he used with. So when people with those kind of odds start to make it, it inspires me. And when the odds are stacked against them, but you try and they try and you think of all the people that have failed and then he does it, that's inspiring. Actually, every addict who comes in here and makes it inspires me.

Because improved physical appearance is indicative that recovery is taking place, praise by the group that someone is looking well is not only complimentary to the member but also affirms that his progress and success in recovery have been witnessed and appreciated.

12.3.8 Change in physical behaviour as an aspect of recovery pedagogy

Another aspect of the physical reality of recovery is behavioural change — opening up to the world again after having existed in a closed-off, narrowed space during addiction. An addict planning to attend group meetings demonstrates a change in her physical use of space in the world as well as a commitment of her time: a widening of her life to embrace recovery.

Rio spoke about the simple behaviour of coming regularly to the group as an indication of commitment to change:

Firstly, if you attend regularly you are demonstrating that this recovery is a very important part of your life. You are showing your commitment. By making that time a part of your life, you consciously schedule this in. The addict makes a conscious decision and consciously schedules time: I have a problem and I need to do something about it — on a weekly basis, twice a week, thrice a week — or whatever level of commitment you want. It's at a core level of living: you wake up for breakfast, wake up for gym, wake up for life, go to a meeting. If you do that, then at a very basic level you are recognising that there is something wrong with you, and then you make time for it.

The commitment of attending then affects the participant's behavioural choices outside the group as well, as shown by Nikhil:

Just this week I had a major problem with my ex and my son, and my thoughts went to the bottle. But the work that I have done on myself led me to pick up the phone, phone my psychologist and ask him for a session. So instead of driving to the bottle store, I drove to have a session with him. And also, because I was in the area, I came for this meeting.

Alexis also described change in her behaviour:

And on Thursday I said to myself, "Do I need a pill?" and I said "No, I don't need a pill: I've got counselling." And I went back there. And the doctor came, and I offloaded on the doctor and she gave me many ideas.

The world of the addict in recovery opens and deepens, as do her options. This stands in contrast to her restricted world while in addiction.

12.3.9 Body boundaries

The body is the locus and focus of addiction, recovery, relapse and cravings. A significant change that occurs in the recoveries of many addicts is the development of vigilance regarding whether addictive substances enter their bodies — which could cause a relapse.

One group member wondered why he was constantly craving alcohol and connected it to his regular use of an alcohol-preserved mouthwash. In a study by Hirschman (1992), a participant shared the following on this topic: "Mouthwash contains 13% alcohol. I'm just afraid that once that alcohol taste gets in my mouth, I'm a goner. ... I still have dreams where I wake up tasting bourbon in my mouth". The body as a boundary becomes more defined in recovery, as one slip can trigger a relapse for the vulnerable addict.

Mervyn commented on his experience with this:

I do not eat food with alcohol in it. I do not take medicine with alcohol in it. I am vigilant, but I did make a slip up whereby I took Bioplus for a few days and my partner realised it has alcohol as a preservative and I read it and I was upset with myself. The person here to blame is me: I need to be more vigilant in my recovery. I do go out with the guys and you find you start to smell your alcohol — you take

a slight sip, to see if there is any foreign taste in it and things like that. If I buy a cooldrink it will be one with the lid on — one of the 500ml bottles — and after I drink, I put the lid back on. You find there's a lot of mechanisms you put in place to be conscious of getting spiked by alcohol. I'm very vigilant.

Hirschman (1992) reported that two addicts in her study refused to permit novocaine injections during dental surgery, preferring to experience pain rather than have drugs enter their bodies. Another refused to eat some sauce because his mother had "poured some beer into it for the taste" (Hirschman, 1992, p. 545). Despite his mother explaining that the alcohol had been cooked out, what mattered was that the beer had been present and he drew a strong line as to what he would allow to enter his body. Hirschman (1992) described the sense of betrayal an alcoholic experienced after discovering that the cake he had eaten at a friend's house was flavoured with liqueur. He commented: "I just don't want alcohol to be in my body ever again" (Hirschman, 1992, p. 545). Another recovering addict said how she "hates to get a cold, because when I do I won't take sinus medication. It makes me drowsy and reminds me of when I was using [drugs]" (Hirschman, 1992, p. 545). Participants in the present study indicated that they refused to drink non-alcoholic beer, as they had seen members of the recovery group relapse into alcohol addiction after doing this.

Through recovery, the relationship of the addict to her body changes from being a "thing-body" — as Kemp (2009) describes it — to being something to take care of, pay attention to and respect. From an attitude of indifference and destructiveness to one of attuned vigilance, the addict transforms herself through her conscious awareness of all aspects of the physical and that, in turn, opens up consciousness and possibilities in the world (Kemp, 2009).

Jashwin summed up the transformation of the addict to a life characterised each day by conscious and healthy awareness:

It's like a teacher who says, "I taught for twenty years," but you could have taught one day over and over for twenty years. So for me, having 913 days clean: for me I put 913 different things right, using every single day. Sobriety is different from recovery. Being sober means total abstinence from substances that you used. But

recovery is a wholesome process — where the mind, the body, the soul is all undergoing a metamorphosis.

12.4 CONCLUSION

This chapter has focused on various physical aspects of addiction and recovery. Included in the physical realm is the physical experience of the addict's body, cravings, experience of the world and behaviour in both addiction and recovery, using neuroscience to assist in highlighting links between the physical and the conscious parts of an individual. The chapter explored the pedagogy that emerged from the recovery group. It showed how it worked with these physical aspects to help participants overcome addiction and maintain recovery, revealing the opening to the self and the world through the group process of recovery.

12.5 CONCLUSION TO MECHANISMS OF TRANSFORMATION

The first two questions of this study have been addressed:

- What in, or about, the group assists in the maintenance of the recovery of regular participants?
- What processes of teaching and learning took place in the addiction recovery group?

These were answered by examining the nature of the recovery of regular participants and finding that this embraced many fundamental aspects comprising the person; namely, their religion and spirituality, psychology and emotions, and physical aspects. Each of these three sections detailed the findings that emerged and located them in their own literature reviews, while accounting for them in the write-up of each chapter by focusing on the transformation and the group mechanisms of participant transformation, which worked hand in hand. These personal aspects have been named 'Mechanisms of Transformation'.

The following chapter answers the final question of the study, examining what knowledge helps participants maintain their recoveries. It does so by applying various concepts from communities of practice theory to give as full a purchase as possible on matters of claims to competence, membership, knowledge and Regime of Competence (also called Repertoire of Comptence).

CHAPTER 13

CHAPTER 14 FROM COMPETENCY FRAMEWORK TO REGIME OF COMPETENCE

13.1 INTRODUCTION

The previous chapter examined the physical aspects of both addiction and recovery maintenance and pedagogy, concluding the findings of this study relating to the Mechanisms of Transformation that affected the group participants' spiritual, psychological and physical transformations. This also concluded the chapters addressing the first two questions that guided this study:

1. What in, or about, the group assists regular participants to sustain their recoveries?
2. What pedagogic mechanisms are used in the group?

Chapter 13 seeks to answer the third research question, namely, what knowledge helps the group participants to maintain their recoveries over time?

The chapter introduces two terms: 'Competency Framework' and 'Regime of Competence'. While the previous 3 chapters described the "Mechanisms of Transformation", i.e. the group rules and processes that enabled the participants to develop understanding, gain insights, and grow in their determination to maintain their recovery, this chapter explores the competencies (i.e. presents a framework of competencies) that need to be developed during that journey of recovery. Once the addict practices / enacts the competencies contained in the framework (e.g. regular meetings, no substance use, recognising and learning to avoid triggers that awaken desire) then the addict can turn these competencies into a habitual way of being, and thus live their life within an space bounded by these habits. This chapter presents findings which address the third, and final, question in the study:

3. What knowledge helps participants sustain their recoveries and what knowledge is useful to them in the maintenance of recovery?

It explores what knowledge participants perceived as useful and discusses what curriculum assisted participants to maintain their recoveries. It does this using the communities of practice lens.

The concept of a competency framework is introduced in the first part of the chapter. Here the construct of 'competency' within the practice includes knowledge claims (Wenger, 2011) within the addiction recovery practice of this study. The specific practice developed within a community functions as a "living curriculum" (Wenger, 2006, p. 4) and the notion of a framework of competency, which reveals the findings which emerged through focus-group work to be key competencies of recovery in this particular practice, are discussed. What is important about a competency framework is that it also indicates incompetency, and this is also important in the context of this study. In short, the competency framework is equated to a curriculum (in that it functions as a curriculum) and the regime of competence is equated to the qualities / outcomes / set of reference points that group members hold each other accountable to in terms of what has been developed and found important by the addition recovery group / practice. The Regime of Competence is the power aspect of the practice that enforces those traits and behaviours necessary for recovery, the Competency Framework.

The first part of the chapter examines the Competency Framework of the recovery practice, in which the findings are presented in the form of two tables. The first table shows the competencies that participants stated were necessary in order to recover, then their rankings by these participants, in order of importance to recovery. The second table illustrates the emergence of those competencies within the process of recovery over time. It also shows their movement from newcomer to old-timer within the particular recovery practice of this study.

In terms of the second part of this chapter, the communities of practice technical term, Regime of Competence, is used. For Etienne and Bev Wenger-Trayner,[3] a community of practice contains a 'regime of competence'. This refers to the power or authority aspect of a practice, where members can call each other out when specific conduct and particular expectations of the community of practice are disregarded (Wenger, 1998b). Here,

[3] Etienne Wenger and Bev Trayner changed their surnames to Wenger-Trayner when they married in September 2011.

communities are social groupings where their members display certain competencies and are recognised as competent through adherence to expected conduct and values of the practice (Wenger, 1998b).

The Regime of Competence is linked to a process known as ‘alignment’, which relates to how members behave with regard to the activities and regulations of the community and in this way align themselves to the practice (Wenger, 1998a; Wenger-Trayner & Wenger-Trayner, 2014).

The terms ‘community’ and ‘practice’ used in the communities of practice theory are used instead of ‘group’ in this chapter, as the theoretical lens of communities of practice introduced earlier in this study is used for analysis in this chapter. From a communities of practice perspective, human learning is considered a social act. In communities of practice theory, there is a relationship between competency, community, learning and identity (Wenger, 1998b). These aspects speak to the various findings of this study.

13.2 CLAIMS TO COMPETENCY

In this study, the term ‘competence’ is used to assist in the understanding of the addict’s transformation within the group. The term refers to the various knowledge claims by practitioners of a particular practice. It emerges from a practice and is not imposed externally regarding what practitioners need to know or do in order to achieve the outcome of the practice from the outside. The term ‘knowledge’ is not used in communities of practice theory, but instead the focus is on competence within a practice — in this case, competence within a practice of addiction recovery.

13.3 COMPETENCY FRAMEWORK

The following section provides a background on the development and function of the notion of a competency framework in order to locate the focus group findings on this topic, presented and discussed later.

The concept of a competency framework emerged in the field of human resources in the 1970s (Sultana, 2009) with the intention of analysing what needed to be done in particular jobs and at what level. Exemplary leaders were studied, and their key interests, abilities, traits and areas of knowledge were categorised and organised into a framework. This was then used for the selection, assessment and development of managers (Sultana, 2009).

A competency framework provides a useful tool for unpacking the requisites of a practice or profession by making its skills and knowledge explicit, as well as identifying key processes and technical terms. As such, a competency framework can help to highlight gaps in knowledge, skills and processes, and can serve as a valuable guideline to promote the identification of these and aid in the self-development of its practitioners (Sultana, 2009). It thus provides a useful tool to highlight aspects of competency considered essential by the participants of this specific recovery practice. It can be considered in a similar vein to a curriculum in this context (Sultana, 2009). Examples of competency frameworks and curricula can be found in different disciplines (Atherton et al., 2008; Nikolov et al., 2014; Roggema-van Heusden, 2004; Roth & Pilling, 2008; Voogt & Roblin, 2012).

The notion of a competency framework spread to other disciplines, such as education, where it became popular in areas such as vocational education and training, and teacher training and development. This became known as competency-based training in the 1970s and 1980s, and spread across Australia, America and Europe. However, by the mid-1990s, this approach began to face criticism (Sultana, 2009).

13.3.1 Critiques of the Competency Framework

Both the notion and the definition of competency have been critiqued. The lack of a precise definition of the concept was criticised — for example, the word "competency" is often used interchangeably with "knowledge", "skill" or "ability" — on the grounds that it does not increase understanding or knowledge of the world (Sultana, 2009). It has also been critiqued for the epistemological notions underlying it, specifically behaviourist notions, as it was outcome- and behaviour-focused. The major criticism was that the focus was reductionist, focusing on behaviour and outcome primarily, and that the person of the learner (for example, their motivations, passions and prior beliefs) was lost in the

process. The main objections were along cognitivist and constructivist lines, as this model is behaviourist in nature. The notion of social learning was not addressed either (Sultana, 2009). The notion of a competency framework has been criticised as inadequate for training professionals (Akhurst et al., 2016; Talbot, 2004), for its failure to adequately take culture and context into account (Collins & Arthur, 2010), and for which contexts and situations competency frameworks are valuable (Morcke et al., 2013).

There have been attempts to address the critique around the definition of competency. Many seem to agree that while there is no one definition embracing all possibilities, there is agreement that the term should not be used narrowly, referring to a technicist, skills-based definition, but should be used more widely (Sultana, 2009). A popular definition based on consensus extracted from documents and research from France, the United Kingdom, Germany and the U.S., is the following provided the European Commission (2005). Using the work of Coles and Oates (2005) competency includes five different aspects, namely (i) cognitive competency – the knowledge aspect, which involves the use of theory as well as knowledge gained experientially; (ii) functional competency (skills or know-how), which are those things that a person should be able to do when they are functioning in a given area (iii) personal competency refers to knowing how to conduct oneself in a specific situation; and (iv) ethical competency relates to the possession of certain values. All of these five aspects can be directly applied to the community of addiction recovery in this study.

For Sultana (2009), this definition introduces a human aspect (humanism) in its acknowledgement of the complex nature of knowledge and he explains this in terms of *savoir* (knowing), *savoir faire* (doing or knowledge of how to do or make something), and *savoir être* (knowledge specific to being) — introducing a lived, human aspect into knowledge, such as values, attitudes, motivation, and resources. These three types of competency are integrated holistically such that a competent person is considered capable of combining various aspects of knowledge and skill in answer to the demands that arise in specific contexts. This definition has introduced a dynamic and adaptive aspect to the term. In addition, competency is considered to be developmental, ranging from novice to expert: Sultana (2009, p. 21) gives the example of "having access to a body of specialist knowledge, ability to analyse problems qualitatively and displaying strong self-monitoring skills". It is fascinating that regardless of the profession or practice, these

three traits develop in relation to it; this will be seen in relation to the competency framework of the recovery practice in this chapter.

The competency approach has been criticised for reducing learning to components of proficiency and highlighting an a-contextual and alienated approach to learning, rather than acknowledging learning as process (Akhurst et al., 2016). As will be seen in the competency framework developed in the present study, proficiencies are important, and the aspect of chronicity has been added to account for the process.

Criticisms of competency-based approaches have also focused on their tendency to reduce and fragment processes which are necessarily complex and integrative; their imposition of externally defined criteria for competency rather than facilitating the identification of competencies by participants; and their dismissal of the reality that competency is better 'caught than taught': mastery is more the result of socialisation into and by a community of experienced practitioners than focused training (Sultana, 2009). These critiques suggest that the identification of competencies and expression of a competency framework needs to be open-ended in both scope and spirit (Sultana, 2009).

Within this particular recovery practice, competencies were not imposed but were expressed — 'caught' rather than 'taught' — and mastery was developed as result of being shown the way by old-timers.

It is against this backdrop that the competencies that emerged in the study need to be considered as the knowledge and curriculum necessary for addiction recovery in this practice, as well as the four criteria listed by Coles and Oates (2005), which are relevant to understanding various aspects of recovery competencies.

13.3.2 Framework of competencies identified by participants

The eight participants of a focus group in the study were asked to draw up a list of the competencies (skills, knowledge, behaviours, and attitudes) that they felt were fundamental to their recoveries. They were then asked to rate the competencies as: core (most important), important, or less important in their experience of recovery practice (see Table 13.1). The participants were then asked when they had developed that specific competency during their recovery: as an inpatient, within the first three months, within

three to six months, within six months to twelve months, or after more than a year (see Table 13.2). The last category indicated that they were still learning that particular competency.

This exercise thus identified the competencies themselves and their importance to those in this recovery practice and tracked their emergence over time. This process was a way of plotting the curriculum of this particular recovery practice.

A relationship exists between the desirable competency framework and the regime of competence that allows the member of the practice to develop the desired competency. Members, through the regime of competence, can challenge and keep each other in recovery.

13.3.2.1 Ranking of competencies

Table 14.1 Combined rankings of listed competencies essential for addiction recovery

COMPETENCY	RANKING	RANKING OF IMPORTANCE		
		Core (most important)	Important	Less important
Development of integrity **(honesty, reliability, reputation)**	**1**	8	0	0
Building trust (within self and others)	**1**	8	0	0
Breaking denial	**2**	7	1	0
Managing emotions	**3**	6	2	0
Working on procrastination	**3**	5	3	0
Perseverance and willpower	**4**	5	3	0
Cultivating hobbies **(good uses of time, keeping busy)**	**4**	5	3	0
Learning to say no	**4**	5	3	0
Developing self-esteem, self-respect	**4**	5	3	0
Planning daily and longer term	**4**	5	3	0
Awareness of triggers	**4**	5	3	0
Increased belief in higher power	**5**	3	2	3

The most important competency for all eight of the focus group participants was the 'development of integrity' (which included honesty, reliability and reputation) which tied for first place with the competency of 'building trust within self and others'. The competency of integrity relates to the transformed self of the addict — indicating the importance of a stable, reliable sense of self as the basis of recovery.

'Breaking denial' was ranked second, as seven participants considered it core and one considered it important. This competency is considered critical to addiction recovery, as recovery cannot occur without it. This finding emerged in individual interviews and has

been written up in the chapter on honesty. Denial can also creep back in to the addict's mind during the process of recovery, as was often mentioned in the group. Regular group attendance, which enables others to point out an addict's blind spots, is essential. This highlights one of Sultana's (2009) categories which is evident in all competency frameworks: the development of self-monitoring skills. This aspect lies in the interaction between the competency framework and regime of competence.

In joint third position were 'managing emotions' and 'working on procrastination', considered core by six of the eight participants. Both of these can be considered self-management and self-regulatory competencies, and require the competencies mentioned above to have been achieved or be on the way to being achieved, in order to be achievable. These competencies require a new skill set and learning from others in the group often provides this. Again, the participants are developing self-awareness and self-monitoring skills, which concur with Sultana's (2009) findings.

Six of the competencies given by the focus group ranked at joint fourth place. Three of these can be linked with the self-regulation competencies just mentioned: 'perseverance and willpower'; 'developing self-esteem'; and 'learning to say no'. The other three speak to more specific skills: 'cultivating hobbies, good uses with time, keeping busy'; awareness of triggers'; and 'planning day by day and generally'. All of these give the recovering addict a sense of purpose and control of her life.

The competency of 'developing self-esteem' is important and needs to be considered in the context of the breaking down of self-esteem written about in the discussion on shame in Chapter 7, and the building up of self-esteem discussed in Chapter 11. Here we see an antidote to the rejection by others and by the self of the individual in terms of both acceptance and belonging to a practice, and the development of life skills (assertiveness, planning, cultivating hobbies, awareness of triggers) which, over time, combine to build the self-esteem of the participant. It is fascinating to note that at the beginning of recovery, by setting small goals and reaching them over time, one begins building a reliably based self-esteem that later impacts on the self-structure of the addict.

Examples of Sultana's (2009, p. 21) "having access to a body of specialist knowledge" are seen in learning to say no (understanding of assertiveness) and awareness of triggers and planning skills; the ability to analyse problems qualitatively is seen in learning to say

no, awareness of triggers, managing emotions and working on procrastination; and the latter are also indicative of strong self-monitoring skills.

This study found that the competency framework covers many aspects of the development of the person in recovery: from the development of their basic selves, to emotional management, self-regulation and the development of a new repertoire of skills and coping strategies. All of these emerge and work together over time, combining in the positive transformation of the addict in this practice of recovery. That recovery affects the whole person is illustrated by Table 13.1, which shows the various competencies that the recovering addicts have learned in this recovery practice, which can be likened to a curriculum that they have developed.

The final category was 'increased belief in higher power'. What emerged was that for those who were spiritual or religious, this aspect of their lives was enhanced, while for those who were not, it was not. Recovery did not result in those who had not been religious becoming religious, in this particular practice.

13.3.2.2 Time required to develop competencies in addiction recovery

Because addiction recovery is a process, it is important to include the aspect of time in the competency framework in order to understand the development of competencies across the trajectory of recovery. One of the criteria for inclusion in this research was that participants had to have been in recovery from their addiction for a year or more in this particular group. The reason for this was that they needed to have sufficient experience of the group and of recovery in order to comment meaningfully on the phenomenon of this study.

Table 13.2 shows the same competencies, indicating the timeframes in which the eight participants of the focus group reported that they had developed them. The competencies are discussed in the order in which most participants reported they were developed.

Table 14.2 Length of time over which competencies for addiction recovery developed (eight focus group participants)

COMPETENCY	PERIOD OF TIME TO DEVELOP				
	Inpatient / newcomer	**0–3 months**	**3–6 months**	**6–12 months**	**12 months plus**
Breaking denial	8	0	0	0	0
Keeping busy, cultivating hobbies	4	4	0	0	0
Perseverance, willpower	3	3	1	0	1
Planning day by day	1	3	1	0	3
Awareness of triggers	0	5	2	0	1
Work on procrastination	0	3	0	0	5
Develop integrity **(honesty, dependability)**	0	1	4	1	2
Managing emotions	0	0	1	0	7
Increased belief in higher power	Stayed same for them all, regardless of belief				
Building trust **(in self and others)**	0	0	0	4	4
Developing self-esteem, self-respect	0	0	0	4	4
Learning to say no	0	3	0	0	5

Breaking denial. For all eight participants in the focus group, the competency of 'breaking denial' happened first. Until the addict realises that she has a problem, no transformation can occur. This is the first step, then, to taking responsibility for personal transformation. As McKenzie said:

> *If you want to recover you have to get rid of denial. When I actually realised I had the problem* [of addiction]*, my denial disappeared. I went back to my psychiatrist and said, "I have got a problem: I want help." But until you want that help: forget it.*

Karen made a similar comment:

> *Ten people can send you to rehab — your mother, your mates, your boss — but until you acknowledge it, it isn't going to work.*

Vega agreed:

> *I truly believe that the only way you can recover is when you yourself make that acknowledgement.*

Breaking denial and owning your own recovery is thus the first step towards finding one's authentic self and a new identity that is not based on being an addict.

Keeping busy; cultivating hobbies. For all participants, by three months into recovery the skills of cultivating new hobbies and keeping busy had become entrenched. The importance of this is that distraction is critical and having new ways to pass the time is vital. This also demonstrates behavioural change occurring before cognitive and emotional change: to recover, one must establish new behaviours before anything.

Perseverance; willpower. The traits of perseverance and willpower were considered by three participants to have developed during their inpatient stay. However, in discussion, it emerged that they began to develop these traits and were really talking about their commitment to recovery. Three others felt they had mastered the crux of these traits by the end of three months.

Awareness of triggers; planning life day by day. Awareness of triggers was developed by most of the participants by three months and this seemed to go hand in hand with planning life day by day — in other words, planning one's day in order to avoid triggers.

In terms of triggers, Karen said:

> *There will never be the book on how you recover — it's different for everybody and we need to learn from each other and take and adapt, and at the same time there are a lot of things that have been shown to work and we have to acknowledge those: not to pick up the first drink, PPP, that we need to change and that we can't expect to stop drinking and not have to change. We have to start to change and*

> *look at what it is about me and the way I live life that makes me need to drink. We need to go to meetings, especially in early recovery.*

All of these strategies are part of self-management, and the management and regulation of emotions.

Jashwin performed the role of the broker between practices in the group as he belonged to a variety of recovery practices. He said:

> *I bring to the group my readings, my understandings, from other groups that I attend. It's a fresh input: other insights, information, initiatives to the group. I read recovery-related books, I get emails every day, I read Hazelden literature and other group attendance, and I do the steps.*

Jashwin brings knowledge from other practices into the group, which allows members to enrich their understandings and practices of recovery. For Mervyn:

> *There's a lot of things you learn from the group — lots of knowledge you learn from other people, people in recovery — pertaining to relationships, addiction, finances, work, friends. It's an abundance of things you pick up.*

Again, we can highlight Sultana's (2009) three dimensions of competence: having access to a body of specialist knowledge can be seen in the awareness of triggers and counting days; the ability to analyse problems qualitatively is seen in managing and planning for various situations; and displaying strong self-monitoring skills is summed up by addiction counsellor Stephen's dictum of "awareness, awareness, awareness".

In short, by three months, approximately half the participants (3 – procrastination and 4 – daily planning) had implemented behavioural changes through planning on a daily basis, beginning to tackle things without putting them off.

Developing integrity. From about six months, the beginnings of deeper, structural changes to the self emerged, with half of the participants having noted shifts in their integrity, honesty and dependability.

Developing self-esteem/self-respect; building trust in self and others. Half of the participants laid claim to having developed self-esteem and self-respect, and building trust in themselves and others at a year.

Trajectory of change

Table 13.2 indicates that the participants only really began to experience structural change to their selves at around six months into recovery; this suggests that people serious about recovery should commit to attending a support group from at least six months onwards as the behavioural changes which have begun before that have not truly started impacting their deeper selves yet. This confirms research by Gossop et al. (2008). And while the initial behaviour changes a person has made may have become part of their daily routines, they have yet to be integrated into the self of the addict. This is confirmed by the fact that the other half of the participants indicated that they were still developing and consolidating trust and self-esteem after a year, showing that it takes time to integrate and consolidate a new sense of self. This confirms research by Fiorentine (2000), Kissin et al. (2003) and Timko et al. (2000). It also contributes that the reason for this is because of changes to the self.

After a year, most of the participants were still working on the competencies; some called themselves a 'work in progress' during the focus group.

Procrastination was still being worked on after a year — which indicates the internal struggle of taking responsibility and action, and how easy it is for the addict to avoid facing what they consider to be unpleasant.

Managing emotions. Procrastination ties in closely with **managing emotions** — a central issue in addiction recovery which almost all participants indicated they only began to master after a year. This highlights the need for group support on an ongoing basis even after a year of recovery. In an individual interview, Stephen shared:

> *I used to hate being alone. I would come and there was no one there and I couldn't handle being alone, so I would go to a bar. … I do think my addiction was about not liking me. I didn't like being me … I wasn't at ease with myself. There was always something off kilter. I didn't feel right. I couldn't relax into other people's*

company. … When it came to my recovery, I still have that uncomfortable feeling in me, but I have learnt to know how I feel, and it has got less. Because I can talk to strangers … but I don't feel uncomfortable with myself anymore.

Part of Stephen's journey of recovery involved learning to speak out in the recovery group and learning to tolerate the anxiety and discomfort he always felt within himself. Being in a social learning setting, with all its complexity, facilitated his making peace with himself and learning to interact with the world as the person he wanted to be.

Zimo shared:

I started feeling better with myself even though I felt depressed. My counsellor said, "It will get better," and I realised I had to change my attitude. And when I did, there were a lot of changes.

Stephen added that recovery involves more than just stopping the use of an addictive substance:

You hear over and over that the common thread is loneliness and boredom. We use our substance of choice as a way of escape and our coping mechanism for life. So, it's making connections with people and keeping connections with people. Go to meetings. Approach them. Take the step.

Table 13.2 also indicates that recovery, like much of human development, takes different lengths of time for different people. With many key competencies to develop in order to sustain recovery, one can see that the initial hospitalisation is only the beginning of the road to recovery and not the end — as many assume.

13.3.2.3 Summary of the competencies developed in this particular recovery practice within the first year

In this study, the competencies essential to recovery were identified by the participants. Had they been taught from an external curriculum; the competencies would not have been able to be integrated into the selves of the transforming addicts in the meaningful way that they were. When looking at both tables together, the combination of ranking and

timing is revelatory of the practice and process of recovery in this specific recovery community of practice.

For all participants, the development of integrity was the most important competency; this emerged, for most, from six months onwards. It is linked to other issues reliant on deeper changes to the structure of the self — namely, building trust and developing self-esteem, which also emerged from six months onwards and are ranked as the second and joint-fourth most important competencies in addiction recovery.

Recovery is predicated on breaking denial of the addiction, which, while ranked as second, is done while participants are inpatients. Once it has happened, the participant is open to embracing a new repertoire of behaviours, which include planning on a daily basis, cultivating hobbies, and staying busy, and these combine to enhance willpower and commitment to the process of recovery.

The longer the participants continue in their recovery, the more the core of who they are changes as the behaviours, new skills, and understandings and successes impact on the self and self-esteem, and consolidate. Here we see how recovery was learned and sustained in a social context.

The notion of claims to competency within a community of practice have been illustrated with the examples in both tables, thus highlighting curricular and knowledge-related aspects of addiction recovery in this particular recovery practice over time.

This concludes the first part of answering the third critical question: “What knowledge do participants perceive as helpful to them and what curriculum assists participants to maintain their recovery?” The remaining chapter deepens and concludes the answer to this question.

The notion of a competency framework as used here also opens the door to using the regime of competence tools found in communities of practice theory to deepen and broaden understanding in order to more fully answer the third question.

13.4 REGIME OF COMPETENCE IN THE RECOVERY GROUP

A community of practice contains a 'regime of competence', which refers to the conduct and expectations related to membership of the specific community of practice that have evolved over time (Wenger, 1998a). The 'regime of competence' is also known as the power aspect of the community. Power refers to the authority of members of the community over other members in terms of the practice. This section reports and discusses this study's findings in relation to how members, who have authority over each other as given within the practice, hold each other accountable to their recoveries.

13.4.1 Understanding a regime of competence within a community of practice

A 'community of practice' is an informal, dynamic social structure which has developed among its participants over time. A 'regime of competence' includes (Wenger, 2010, p. 2):

- an understanding of what is deemed important, what the enterprise of the community of practice is about, and how the community develops a particular perspective on the world;
- being able (and allowed) to engage meaningfully with others in the community;
- using and applying the specific repertoire of resources that the community has developed and accumulated over time through its history of learning.

It is important to be clear on the difference between the competency framework — which functions as a curriculum — and the regime of competence. For Etienne Wenger-Trayner (E. Wenger-Trayner, personal communication, July 17, 2017), the regime of competence of the community is what members hold each other accountable to in terms of what has been developed by the community by pursuing the enterprise of the practice — in this case, what has been developed and found to be important by the addiction recovery group/practice. It may be that some of the competencies (from the framework) become part of the regime of competence. An example of this from the findings in this study is the notion of honesty, which is both a competency to be developed as well as essential to the regime of competence (discussed fully in Chapter 9 on honesty).

Wenger (1998b) uses the word ‘regime’ to emphasise the power dimension of learning: members of the practice have the power to determine whether others in the practice are demonstrating competency or not. A regime of competence is the set of reference points to which members of a practice hold each other accountable.

In Cain’s (1991) study of AA, competence was measured by members’ ability to tell the AA story in a particular way — the assumption being that one had to have come a certain distance in one’s sobriety in order to tell that particular story and for it to be one’s own.

The addiction recovery group, as a community of practice, created a regime of competence which enabled the group to develop a competency framework for recovery from addiction. Membership and accountability were aspects which were found to be essential to the transformation of addicts’ identity in this regime of competence. In the tension between the ideal competency framework and the regime of competence that enables participants to transform their identities in reality, lies the “liveable path” from addiction to recovery, as expressed to the author by Etienne Wenger-Trayner on BEtreat in 2017.

13.5 THE WARNING BELLS OF RELAPSE

Relapse begins within the thoughts, fantasies and emotions of an addict before it finally manifests in their behaviour. The role of the recovery group is to support the addict through a process of learning to handle these thoughts and emotions differently, so that the behaviour of using an addictive substance does not re-emerge.

While there was often discussion in the addiction recovery group regarding whether one could recover on one’s own, what emerged in the findings is that that while one might be able to stop using without help, it is only through membership in a group (practice) and accountability to a practice that one can remain vigilant of one’s blind spots and sustain recovery over the long term. Accountability in the group thus focuses on flagging addictive thoughts, emotions, attitudes or behaviour exhibited by a member, and calling him or her on it.

13.6 MEMBERSHIP

Wenger (2011) explained that in his communities of practice theory:

> [m]embership implies a commitment to the shared domain of the practice, and therefore a shared competency that distinguishes members from other people. The domain is not necessarily something recognized as expertise outside the community. However, within the community, they value their collective competency and learn from each other. (pp. 1–2)

In other words, membership is self-selected within the practice and the agency to select membership belongs only to members of the practice. It is also important to bear in mind that the criteria for membership of the group may not necessarily be the same as membership of the practice. Three types of membership are described below. The categories are not mutually exclusive.

13.6.1 Membership: Newcomers versus old-timers

"Sympathy is easy because it comes from a position of power. Empathy is getting down on your knees and looking someone else in the eye and realising you could be them, and that all that separates you is luck."

— Dennis Lehane (2012), Northeastern University graduation ceremony

The apprenticeship model was the original model of non-formal social learning posited by Lave and Wenger (1991). It provides a lens for examining the role of membership within the regime of competence.

Wenger (1998b) defines three different types of membership within a communities of practice structure:

- full participation;
- peripheral participation; and
- marginal participation.

These forms of membership are distinguished by the continuum of participation to non-participation, and the trajectory of the person in relation to the community of practice. A

full participant is on an insider trajectory, maintaining their membership through participation in the practice. A peripheral participant has partial participation and their non-participation in certain practices is seen as an opportunity for further learning about the practice. Their trajectory may be inbound or may maintain a peripheral track. The partial participation of marginal participants is seen as a barrier to full participation: they will either stay marginal to the practice or leave it completely on an outbound trajectory (Wenger, 2010). As the beginner or novice moves from the periphery of a community to its centre, she becomes more actively engaged in the practice of the community and eventually assumes the role of an expert (David, 2007).

In the context of the addiction recovery group, newcomers were inpatients undergoing rehabilitation at the clinic. During group meetings they were considered to be legitimate peripheral participants and their role was to listen and learn from the old-timers — they were on the 'outside' in a liminal space where they could become one of the three categories of member described above. This liminal space in terms of frequency of attendance, group commitment and participation, was not differentiated either theoretically or for purposes of this study. As a newcomer learned the formal and informal culture and values of the community of practice, he became a legitimate member. Essentially he moves from peripheral to full participation.The pedagogic aim of this practice was that newcomers would learn from the old-timers. If they chose to continue attending the group as outpatients after they were discharged from the clinic, they moved from this peripheral position in the practice to a fully integrated position. Over time, they themselves became old-timers with expertise to share with newcomers. In terms of partial participation, others would not return to the group once discharged from the clinic, and still others would continue to attend the group occasionally.

Vega commented on this:

> *So when I was discharged, I went straight into it [the group]. I chose to. When I did start coming it took time and then I left and then I came back. I was spiralling and in huge trouble, heading for a relapse. And when I came back it was like, "Wow, I'm home!"*

This feeling of belonging was experienced by other members. Zimo articulated it this way:

Because as much as you can have friends and go out with them now and then, you come to this place and you have that sense of belonging, 'cause you are with people that you relate to — unlike when you are outside, you are going to talk other stuff. But when you come in here, from the morning you are motivated: you have a purpose, a place to go. I know, at least, that if I have a story to tell, I can share it with people who will understand it.

Here, Zimo touched on aspects of identification, shared journey, acceptance and understanding, which are important aspects of membership discussed and elaborated on throughout this study.

Old-timers typically had a very positive and inclusive attitude towards the inpatient newcomers. Karen explained how old-timers served as role models to newcomers:

It's good for them to come and get advice from addicts themselves. We do have a responsibility. When outpatients talk about their day, hopefully it motivates inpatients to want to get to that point as well.

Observing inpatients in the difficult early stages of recovery sparked empathy in old-timers and also motivated them to stay strong in their commitment to sobriety:

I'm glad that they [inpatients] *come in because it has helped me, and I want other people to get help as well. It's a good thing that other people keep on coming; I really think it's good because you never know what might happen: if they relapse, it could kill them. That's why new people coming in all the time, that's good, because it gives them* [old-timers] *motivation to stay sober and clean up their lives. I think it's a good thing. — Boet*

New faces remind you of your own recovery beginnings and what it was like, compared to now. It strengthens you. You see new faces; you look at these new faces and it makes you think of the days when you were here — remember what you were going through. You sympathise with them and it keeps you going; it keeps you strong, sharp. — Bob

As discussed in the previous chapter on the physical aspects of recovery, newcomers remind old-timers of the suffering that brought them into recovery, as well as the suffering

of early recovery and the distance that they have come, keeping what they have learnt and the important gains they have made fresh in their minds:

> *Having newcomers in the group is an advantage because over three years you start forgetting what you used to do when you were drinking. But when the newcomers come in, they tell you what they did — they're going through a divorce, their parents kicked them out of the house, they're financially unstable — so it's a constant reminder. And the good part about it is that you're in a situation now where you can explain your venture through your path of sobriety and keep them positive, educate them, inspire them to stay sober. And it is such a wonderful feeling whereby you can inspire somebody, and, in the same breath, you are doing good for yourself. You are keeping your mind alert as well. So, there are two purposes in coming to the group: you relate to what the other people are saying, firstly; and by inspiring them you are also sharpening your brain a bit, as well. — Jashwin*

Spero remembered his early days as a newcomer and the warm and accepting reassurance he received from the old-timers who took time out for him:

> *At the beginning, I was a newbie. I was battling with a lot of stuff. And then the older guys in the meeting — after the meeting, when we were having coffee — one of them would come up and would say, "That thing that you said … I've been there; I understand," and "Give it time," et cetera, et cetera.*

The membership aspect of the apprenticeship model is thus fundamental to the personal transformation that occurs through participation in the practice of the recovery group — at all levels of membership.

The apprenticeship model and its pedagogy speak to Sultana's (2009) idea of levels, or layers, of competency and the importance of acknowledging stages of development from novice to expert — where experts are regarded as being able to competently access specialist knowledge, analyse problems qualitatively and display strong self-monitoring skills. The aspect of time and the development of these competencies is also examined. These competencies are discussed throughout this section.

13.6.2 Formal membership

The recovery group included both formal and informal aspects of membership. Formal membership was reserved specifically for those who had been admitted to the specific clinic that had the recovery group for its addiction aftercare patients — it was not open to their families, nor to addicts who had not done their rehabs at the clinic, nor to those interested in addiction, for example.

For record-keeping purposes, outpatients who had elected to return signed a hard copy attendance register book at each meeting, whereas the inpatients who attended signed a printed daily register. The register was handed to the finance department of the clinic who then billed the medical aid funds of the inpatients. This income subsidised the psychologist's salary, tea and coffee for the group, and recovery anniversary cakes. The outpatients did not pay to attend, having been billed during their inpatient rehabilitation at the clinic.

Figure 14.1 Example of a cake made for the recovery group

Another ritual connoting formal membership in the recovery group was the celebration of a member's achievement of a year of sobriety with an anniversary cake. The anniversary cakes were baked by the clinic chefs and inscribed with the word

‘congratulations’ and the person’s name. For reasons of confidentiality an anniversary cake cannot be shown here, but the box cake shown in Figure 13.2, which was made for a farewell for one of the addiction counsellors, is similar. Karen commented on the importance of the recognition of this achievement:

> *When I didn’t come for it, I missed it big time. Its acknowledgement is important. It’s not only my acknowledgement of sobriety but sharing my celebration with the people you struggle with. Quite frankly, my sobriety birthdays are more important than my natural birthdays.*

Markers of formal membership may thus have a deeper significance than may be immediately apparent.

13.6.3 Informal membership

Informal membership refers to when members choose to include and legitimise each other as part of the practice. In this particular recovery practice, it was the particular way members teased each other that denoted this form of membership and showed that the person belonged. It was a way of members assigning belonging which was separate from formal group membership and the facilitators.

Karen described this:

> *The banter that goes on among the outpatients — I enjoy how we tune each other. It’s just a relaxed feeling … you know that it’s secure and you can just open up and speak your heart. And then if somebody’s got advice for you, they will give it to you … it’s just group banter. I enjoy being part of that. I’m telling you; you really do feel part of the group if they pick on you. It’s nice. I enjoy it; it’s nice. And you’ve been accepted — and being accepted is a big thing for me. And this group has really accepted me, and I enjoy it; I really enjoy it.*

Addicts in the group did not direct this type of teasing at the facilitators, which indicated that this type of bond existed solely among the addicts. The word “accepted” refers to Karen being accepted as an informal member of the practice.

This resonates with Brené Brown's TED talk (Restrepo, 2019) saying:

> The opposite of belonging is fitting in. Fitting in is assessing and acclimating. … Belonging is belonging to yourself first. Speaking your truth, telling your story, and never betraying yourself for other people. True belonging doesn't require you to change who you are. It requires you to be who you are and that's vulnerable.

This aspect of membership conveys a permission to the participant to participate freely as they are; it could possibly be one of the first times the participant has experienced this validation of herself.

13.6.4 Full membership

Full membership has a variety of component criteria that emerged for the participants in focus group work. Extracted from the data are the following findings: it is about showing commitment in various ways to the group, including attendance and participation over time; consistency in word and behaviour; and demonstrating a knowledge of recovery. Participants also spoke of membership not being given but being earned by listening to what others say, respecting their feelings and demonstrating personal insight into the recovery process. Full membership is the recognition by other members of an embodiment of the intentions of the practice. It was seen as unlikely that an inpatient could be considered a full member as they had not participated for long enough to earn that recognition, nor would they embody these key elements or the competencies of this practice.

13.6.5 Honesty as an aspect of membership

Honesty has been discussed as a fundamental trait in personal transformation in Chapter 9. Here it is explored as a key criterion which emerged within the practice of recovery and the regime of competence. The data brought to light the various nuances of honesty.

Vega describes how a practice of honesty develops:

It comes over time, speaking about what you have gone through — truthfully about what you have gone through — and the group identifies with that.

Karen's experience resonated with this:

A person can talk openly and honestly about the shittiest things they have done in their life and that's what makes you believe them — because they are clean and honest about it, not full of different stories for different people. So, you begin to lean towards that person. And over time you see how far they have come. And it comes naturally to the group to be the safety net for each other when someone is very sincere about their recovery and trying hard and has challenges, but they don't use that to relapse. There is no manipulation — just openness.

Here we can more deeply understand the importance of the emergence of honesty over time, shown through consistency in word and behaviour, as a criterion for full membership. This is characterised by an open and humble attitude, as described by Vega:

If they are willing to take on board what they have learnt, you can just hear when they speak: there is that attitude. You can tell who is taking it seriously and who isn't. The serious ones want to give this a good go.

Honesty here separates those who are committed to recovery from those who are not. Jashwin described the open and sincere willingness to learn and engage regarding one's own experiences and insights, which is key to membership:

Membership is not given to you, it is earned. You have to earn your place in the group. You listen to what everyone has to say, how they feel. You ask whether you feel like that some of the time, or not. You think about it and put an extra tool in your box.

This illustrates the importance of honesty in terms of openness to learning and not deceiving oneself as an addict. Jashwin described members who were still in denial and had not yet developed a humble and honest attitude of listening and learning from others:

People say they can give up whenever they want to and that they have given up for years. I was like that. I gave up for over two years. But it was for the wrong reason. And they don't learn from other people's mistakes. Someone said in the

meeting today how when he goes home, he will put a whole lot of full bottles [of alcohol] *on the shelf and he knows he isn't going to be tempted. And we had to tell him and tell him. We have a lot of experience in this. We know it. We know if there are mind games and if there is genuineness.*

This quote illustrates again the distinction between those who were committed to their recoveries and those who were not. Jashwin's comment that full members know that having an addictive substance nearby could trigger a relapse also shows the development of knowledge which had taken place within the group. Committed members understood the deception of self that is characteristic in the early stages of recovery because they had experienced it for themselves. Jashwin's description also illustrated the support members gave each other and how they guided each other toward recovery-oriented behaviour, calling each other out when something was said that did not further truth and progress individually or collectively. Graven (2004) notes that a confidence emerges among older members in themselves, each other and their knowledge as they participate over time and observe what happens in the lives of the various group members. This is an example of social learning.

13.6.6 Authenticity

Authenticity, which is the ability to 'walk your talk' and be consistent in word and action, relates closely to honesty and integrity. Because of the importance of honesty and congruence in the group, members became skilled at assessing this competency, as described by Vega:

We can tell who the talkers are and who is genuine. I remember this guy who came once, said he was clean and how he was a pickpocket and did this and did that. And it's horrible to say, but I just knew he wasn't going to make it. I can sit in the group and I know who is going to make it and who isn't: who has a chance and who doesn't.

Part of membership was about speaking authentically; part of that authenticity was knowing what you were speaking about. A reflexive process happened which enhanced the member's credibility. Participants also developed a sense for who was authentic and

who was not, and how that would affect the success of the individual's recovery. Vega provided another example of this:

> *We are able to see a lot more than what they* [newcomers] *can see. For example, there was an inpatient today who was so confident with the wrong tools: overconfident. He was going to go out there, "give up weed and carry on with alcohol". And, "I'm so lucky the cops stopped us but didn't arrest me". Now, for me, I know the consequences of getting caught. I know that you cannot give up weed and carry on with alcohol 'cause somewhere along the line you are going to want to continue with weed — the substance of choice. And that's the knowledge I got in the room.*

This statement illustrates the knowledge about addiction gained by being a full member — in this case, that using any mood-altering substance will take one back to one's substance of choice — and the attitude of humility and openness among members in recovery which eventually replaces the deception and denial characteristic of newcomers.

Jashwin noted:

> *The advice that the person gives in the group can only be advice that comes from burning your fingers.*

This referred to learning from one's own experiences by reflecting critically on them and making the required changes. This process was witnessed and discussed confidentially and respectfully in the group.

Vega followed up:

> *… when people speak about their using experiences, the detail they go into, you can tell who is being genuine. You can tell who is bullshitting and who is not. It's what they say about their addiction, or the amount of the substance of what they take, especially over time. … You've got to be authentic in the group. Who you are in the group is who you are outside of the group.*

Those old-timers in the group could tell who was genuine and who is not. Authenticity is thus important both for one's recovery and in order to be accepted fully as a member of the group. The development of this discernment among old-timers was important to the

group as it pinpointed who was likely to relapse so that that person could be warned, and so that others could take care to not be overly reliant on that person, for their own sake.

Participants in one of the focus groups referred to a group member whom they said had told the group what he thought the group wanted to hear; this had resulted in him behaving as two different people: the one in the group and the one outside the group. He subsequently stopped attending group sessions and, after a short time, they heard he had relapsed. The success of recovery is predicated on genuineness and congruence in the participant; this is seen and valued by the group members, who practise this themselves.

Responsibility as a group member is taken seriously and is demonstrated by resisting relapse and staying clean. In order to achieve this, personal transformation must also be achieved.

Jashwin said:

> *Your moral compass has to be right. And you got to work towards making it right, because we're not all pointing true north — we all work towards it.*

Recovery is thus a process based on recovering, or developing, a morality and continually working, with awareness, on being a better and more conscious person. As Dave, the addiction counsellor said: "*You just keep on doing the next right thing."*

Membership is also dependent on the participant having left — or sincerely intending to leave — their previous addiction or 'community of practice': those they used to drink, or use other substances, with. This is why one of the first and most commonly asked questions in early recovery concerns the issue of what to do with one's drinking buddies or using buddies, as well as how to avoid the local bar or drug merchant, and what to say to them about their not returning. Coupled with this is the intention to now belong to the recovery group and embrace a new community of practice — the recovery group.

Zimo, the only Zulu participant in the study, explained why he believed that a support group for recovering addicts would fail in the townships:

> *Even if it was here in town or in XXX* [he names a local township]*, it wouldn't make any difference. So even if you could put it in XXX, it's not going to change the environment he is in and the people he is around. And the thing is sad because*

> *I've been coming to groups here and there's guys that I've seen here. And* ___ [mentions another person from his township he met during his rehab who had relapsed]*: I knew him from the group, and when he was here, he was so motivated — when he was sitting here — then he went home; relapsed. Ay; that feeling — it's sad.*

Zimo commented that because drinking was an established part of life in his community, it was difficult for someone coming from rehab to sustain his recovery because he could not change his environment. This highlights the difficulty that so many recovering addicts face after they are discharged from inpatient treatment and return to their home environments where invitations and opportunities to drink cannot be avoided.

Another aspect of membership is the safety that belonging to the group provides. As Vega said:

> *Just knowing that everybody is going through the same thing and that there is confidentiality.*

Members could raise difficult issues that they could not or would not speak about outside of the group, knowing that what they shared would be kept within the group.

The aspect of safety was also apparent in the rule that no one attends the group under the influence. This is not the case in twelve-step groups, which allow intoxicated participants to attend if they declare the slightest intention to recover. Because this group is situated in a clinic, this is not tolerated. Not having this rule in AA triggered a relapse in Karen when she attended meetings there. Karen explained that she valued this rule in the recovery group of the study, because she had relapsed after smelling alcohol on someone at AA.

> *People don't like rules and addicts don't like rules, but this is where you are safe. If I go to AA or NA, the chances of sitting next to someone who has used today are huge. And I can't have that. The rule that you can't come if you are intoxicated is huge to me and I don't want to be threatened again.*

Safety and mutual consideration thus emerged as important factors.

13.6.7 "We've been through the war together"

Another aspect of membership is identification with each other. Wenger (2010) describes learning as a process of realignment between socially defined competency (not being an addict) and personal experience (being an addict in recovery). In both cases, each moment of learning is a claim to competency, which may or may not be embraced by the community. This process can cause identification as well as dis-identification with the community. In this sense, identification involves modulation (when one controls or adjusts something with a specific aim in mind): one can identify more or less with a community, the need to belong to it, and therefore the need to be accountable to its regime of competence (Wenger, 2010).

Identification plays an important role in the concept of membership, as noted by Vega:

> *It's like the core group of us: we've been through the war together — and we've come out the other end. And that war that we've been through is what binds us together. And only someone else that's been there or been with you can understand — really understand — it.*

For Vega, recovery from addiction had been the most challenging thing she had achieved; the support of others made all the difference. She described the bond that results as:

> *... knowing that we have been through the same thing. You know what it's been like for me and I know what it's been like for you. And the hard work that it took to come out on the other side and still keep going. Camaraderie: that mutual recognition. For me the hardest thing I've ever done is to recover and stop using.*

The shared repertoire of recovering addicts is important in this example. Jashwin described the mutual respect that results:

> *We all know what alcoholics and drug addicts are like and what they have done, we've all done it. We've seen it. You are not embarrassed in the group. And to know somebody who's come clean — it's the utmost respect for one another.*

Mervyn described the strong sense of identification, both on a personal and a community level, with the group:

> *We are like family in the group. We know what each other has been through, and we've been through the same processes and you can relate to them.*

Jashwin explained:

> *We've built up a friendship as well as all that we have in common. And it's a special friendship — it's not a friendship like with other people. It's different because of what you've all been through. ... We are survivors from addiction. We've been through something and we are surviving every week. You're helping me survive and I'm helping you.*

The awareness that recovery is a matter of survival is not taken lightly: denial has been broken and members realise the destructive consequences that would result if they relapsed. As only twenty percent of addicts survive to recovery (National Institute on Drug Abuse, 2014), this sense of a bond forged in a war is very real.

Jashwin commented on this bond:

> *When I was missing for a few Saturdays, Amith took a drive home to see if I was okay and why I'm not coming to meetings. That touched me. I gave him the biggest hug. I said, "Thank you so much for coming to check on me — I really appreciate it".*

The status of members is derived from the practice itself. Vega described how Amith's competency in recovery increased his status in her eyes:

> *I admire Amith tremendously. Having to work through the loss of his wife and still stay clean at the same time: I am in awe of how he managed to do that. I say to myself, "If he managed to do that and go through something so terrible and stay clean, then I can too".*

The notion of identification was seen to have personal meaning to the participants and thus enabled them to open up to one another. This is the beginning of the building of trust in another and occurred as participants experienced themselves as mattering to others in the group. Identification thus works on a group and individual level.

Mervyn noted that as all of the members of the group had begun their recovery in the same clinic rehabilitation programme, although not at the same time, there was a familiarity to their recovery experience and understanding, which also served as a bond. He explained that the understanding and language used in addiction recovery are specific to that practice and that this sets those within the practice apart from those outside it:

> *People in the group understand you. They understand addiction. If you talk with them, you can relate with them because they are going through the same process. If you go to a friend who wasn't an alcoholic and you explained to him that you are going through this process, he is not going to understand you because he has never been through it. It is like if you put two doctors in the room, they will be able to communicate with each other; but you put one doctor with me and he starts talking about all the medical terms, I'm going to be lost. It is the same scenario, when you put two addicts in a room: they can relate with each other. Take out one addict and put a normal person, and they wouldn't relate because a normal person will not be understanding as to what the addict is — a different type of a bond. It's difficult to explain but it's somebody that you can place all your problems to and knowing that they understand you, they are not judging you, they know where you are coming from, and are understanding that problem because they have been down that path as well.*

Wenger-Trayner and Wenger-Trayner (2014) refer to this aspect of members of a specific community of practice having an insider knowledge and language; for example, the expression 'purple in the nose', which refers to how the wine smells in the glass, would only be understood by someone in the wine-tasting community.

Mervyn described the understanding of the recovery practice shared by members this way:

> *It's like a guy in an army who gets a medal for being a hero and saving somebody's life. He comes and shows me that medal and says, "Here, I saved X's life." I'm going to look at him and say, "So what?" Exactly the same as if I go and tell him that I'm three years sober. He's going to say, "So what?"*

These quotes indicate the specific identification of members of the practice with each other and how important this was to the acceptance and understanding they experienced.

They also reveal how much the members relied on each other for acknowledgement of their effort and progress in recovery, as outsiders would not be able to give them the same recognition. This suggests that the recovery self needs to be consolidated through regular participation and affirmation in a practice with those who are in a position to validate them.

13.6.8 "The group is like socks"

Membership offers a sense of comfort and protection from the intense challenges of facing the world and oneself without the dulling effects of any substance of choice. Karen described a soothing aspect of the group:

> *The group is like socks. They cushion the blow and make things comfortable. We all go through this transition. Every person in the group is at a different phase in their transition. And whether you are clean and sober longer than someone else sometimes is irrelevant. I look at someone who is 56 days sober and listen to him and learn so much from him. So, we can learn something from everybody's story, irrespective of how many days they have. And we can find comfort and relief. So, it is like a pair of socks helping when you walk through your recovery.*

Her words demonstrate that the group's attitude of openness to everyone is fundamental to recovery and allows each member to learn from the others, and that brings connection.

13.6.9 Summary

Membership in this practice is thus critical to recovery. It is both chosen by the member who joins the practice and earned as the member integrates into the practice over time, displaying competencies and earning the regard of others. The sense of safety, belonging and acceptance which members receive facilitates their recoveries. Other aspects of membership of this practice include honesty, authenticity in word and behaviour over time, knowledge of recovery and identification. These competencies support the recovery of each member and help them to resist relapse, bearing in mind that relapse begins some time before the person actually picks up the substance.

13.7 ACCOUNTABILITY

Wenger (2010) explains that

> [t]he regime of competence of a community of practice translates into a regime of accountability — accountability to what the community is about, to its open issues and challenges, to the quality of relationships in the community, to the accumulated products of its history. (p. 6)

Just as the doctoral student enters a community by writing a literature review, so the person with substance abuse enters the recovery community by attending the group and learning how to participate in order to recover. Here he listens to the stories of others in order to get a sense of the knowledge and history of the particular community, so that when he chooses to return as an outpatient he is aware of the issues, knowledge, rules and approach of the group, and is knowingly able to subscribe to them. There is also the sense of identification with members and the working of the community, and the commitment to choosing to belong to it.

A community of practice is not only about sharing goals, but is also a negotiated enterprise, involving mutual accountability (Wenger, 1998b). Working in a mutually accountable way requires a conscious sense of responsibility, with members working with concern for themselves and for the benefit of the community of practice (Moule, 2006, p. 135). This is evident in this addiction recovery practice.

13.7.1 Mutual accountability

Wenger (1998b) notes that "[a]n enterprise both engenders and directs social energy" (p. 82). In a community of practice, the enterprise is complex and is communally negotiated through instrumental, personal and interpersonal perspectives. It relies on developing a regime of 'mutual accountability'. In this mutual accountability, members bear a mutual responsibility to support each other in the practice, enforcing the accountability when needed (Wenger, 1998b).

Formal accountability to the group is seen in the group rules (see Chapter 6 on spiritual and religious transformation). While there may be some overlap, the intention behind the

accountability to the practice holds the participants to the keeping of their word and to being a genuine practitioner of recovery. Living this way makes relapse less of an option, as one has more resources to cope better with oneself and the challenges of one's life. This can be seen in a variety of different ways, illustrated here.

Vega explained that this begins with a change in accountability:

> *My whole day — from the moment I opened my eyes — was focused on where I am going to get my next fix. Which pharmacy was I going to go to: I've been to this one, this one, this one, this one — which is the next one I'm going to go to today. So, it's working out when I am going to go, what to say — so my whole day is thinking about that. I'd sometimes take at lunchtime, and then in the evenings again. Most times it was twice a day. I'd send some codeine down. So I thought about my addiction one hundred percent of the time. I was one hundred percent accountable to that. With the group I now have a completely new set of friends because my accountability changed. Part of recovery is also about giving back.*

Here we see that Vega was previously enslaved to her addiction and this consumed her every waking moment; once she became a member of the recovery practice, however, she became accountable to her recovery and to the people in the group and to assisting them. The entire meaning and purpose of Vega's life transformed with her personal transformation.

Jashwin explained his experience in the group and practice:

> *You are told that your way is not the only way: that your arrogance has to go away, you need to be sensitive and be considerate and that other people are also affected by your boozing. I learnt how to be a better person, a better husband, a better man, a better father. A better neighbour.*

The ultimate intention of recovery is to become a better human being and a better version of oneself because this increasingly precludes relapse; if one does relapse, one would come clean and work with it within the group. The practice holds its members accountable to this in a variety of ways.

Accountability implies power in the group and practice. Only a member of the practice can call out another, holding them accountable to the regime of competence. In the

addiction recovery group, this holds because of the strong identification members have with each other and the high regard they have for those who are further down the road of recovery. I noticed many times during the years I was involved in the group how participants would give each other the same advice their family members had. Because of their identification with and unconditional acceptance of each other as addicts, they accepted the advice from each other, considering it to be good and without any agenda, despite rejecting the same advice previously from others.

A few participants commented on this. Vega said:

> *Accepting advice from other people is important to me now. I never accepted advice before — 'cause I always thought that I knew better. I learned that here, in the group. I still find it difficult with the family because feelings get hurt and things like that. But I can accept advice much more easily from others — especially those in the group saying "such-and-such is a problem: let's change it; let's do something different".*

It is interesting to note her use of the word "let's" — implying that she is not alone and separated from the person giving advice, but that they are with her, accepting her. The accountability here is internal to the practice.

McKenzie commented:

> *Our families are not impartial: they are biased and think they know you.*

This quote speaks to the issue of family members not seeing and accepting the whole of the addict — which is key to recovery, as discussed in earlier chapters — while those who are walking the same path do.

This highlights the importance of accountability within the recovery practice and how essential this is in order to keep each other on track. There are, however, a number of challenges to accountability within the recovery practice.

13.7.2 Lying: Defiling the "sanitising process" of the addict and the community

Lying challenges the accountability of the practice, as well as revealing — if it is found out — that the addict's recovery is on shaky ground, if it has not already completely collapsed. Vega noted that:

> *Lying is one of the most serious ways of letting down the group — lying that you are clean when you are not clean. To come in here week in, week out, sit in the group while carrying on with that life, and you come in here on a Saturday and you mislead everyone with your misinformation and you hogwash us into contributing to some of the things you say. Only for us to find out six months later that you never gave up drinking at all. You betrayed the trust of the group that you'd been given. And one of the things of membership is you have to be honest about abstinence. The other thing is that when you come to the group, and you start looking to borrow money, that's a frightening sign.*

This is frightening for other members because it implies that the person has returned to her former ways and behaviours, and the group members have entrusted themselves to that person only to be let down. Vega described the addicted way of being:

> *The person you are when you are using is just horrible … you lie, you steal, you just think of yourself. That's all you do: think of yourself.*

The selfishness, destructiveness and deception involved in addiction, and how this brings out the worst of the addict, which they aspire to transform through participation in the group and practice, was summed up by Jashwin:

> *When we see people relapse and come back, we realise how important the support groups are. The importance of support. That's where you learn, get your knowledge, and get your life back: with others.*

The group is the place where the addict re-commits to recovery in the witnessing presence of the other group participants. Vega noted:

> *I value life so much more now. I realise how quickly you can lose everything. You can even die. It takes just one wrong decision. I've learnt that here — how it can be all gone.*

Lying violates accountability. Jashwin recounted how he called a group member to account because of his dishonesty:

> *I was out one evening at the casino, having a meal with my wife, and there is this person* [from the group] *gambling. And you come back to group and talk, and we talk about cross-addiction and how people take up gambling and this person looks at me with a straight face and said, "I know a lot of people like that, who do that." I kept quiet for the first week, then I said to the person, "I saw you at the casino, gambling on this night." I was angry and betrayed. I said, "You had the chance last week to open up, and you didn't, and that hurts me and my recovery. I'm now on the path with somebody who is carrying another addiction. And it's not fair. It's not fair to the group. It's not fair to me. We have to be honest with each other in this group. Very honest."*

Jashwin had the courage to confront another member who had lied because of the importance of the person's recovery to his own. If he had not held the other member accountable, he would have colluded with his addictive and deceptive behaviour and thus compromised his own accountability to the group and undermined the new self he was trying to build — opening the door to relapse.

Vega said:

> *It defiles the group if you aren't going to be honest.*

Jashwin echoed this:

> *It taints that unwritten constitution of respect and trust moving forward together. … Being clean works on many levels; it is a sanitisation process of a person.*

Vega noted:

> *Out of choice I feel accountable to the group. I don't want to let the group down. I could do that by even a tiny relapse. Even if I did something small — like maybe took some Adcodols — 'cause maybe I had a headache. I know it's not codeine but would still give me a bit of a high. So, if I came to the group and if I didn't tell them, I would feel like I am lying — I'm lying to the group, deceiving them. And if I left the group, having said nothing, I would feel worse. Just the trust that the*

group has put in me — I would feel like I had failed that, and that I had failed everyone in the group.

McKenzie noted:

Honesty: that's important, because among the members who came here, some of them said they were sober when they were not. And there was almost a fallout when some of the members wanted to walk out and not come back because of the dishonesty other members were displaying.

Accountability to the group, to its individual members, to oneself and to the practice of recovery are thus all important. If dishonesty is not confronted, the recovery space becomes 'toxic' and unsafe. Confronting each other also helps members learn assertiveness and develops their self-confidence. Jashwin used the analogy of belonging to a political party:

You don't have to agree but you show them that respect, because you've come in this group together. It's like we all belong to the Recovery Party and we work along those lines. And if I disagree with someone, I don't have to disrespect them. It's a different ingredient of recovery that I don't have in my recipe of recovery, but it doesn't mean it's wrong.

The whole is greater than the sum of the parts, and if there are parts that are tainted, it taints the whole too. Jashwin indicated that the greater good and common cause is what binds members and implicitly underscored that each person's recovery path is different, yet valid. He used the term "respect", which is also very different from the using addict who disrespected everything and everyone in order to get his substance of choice. This shows how far he had come in his own recovery in terms of building up his integrity.

The group is the first place where participants experience themselves as accepted for who they are and can thus allow themselves to become integrated. Jashwin described the change this brought to his life:

During the month of fasting for Hindus, I'd tell my wife that I'd given up alcohol and meat. But outside home I would chow [meat] *and then come home and nibble on what she had spent all day preparing. I couldn't do that now. I wouldn't. I couldn't do that to my life partner who was doing something to support me. I*

owned up and told her what I had done. And now we do it together, seriously. I'm at home and I prepare the food. … But imagine I did that and then sat in a group and the topic of honesty comes up, and I knew that I was the deceit here. I couldn't do it. It just doesn't blend with recovery. It doesn't blend at all. And it does not blend because it would trigger shame around the deceit and create a gap for the person to relapse.

While living a life of addiction, addicts typically think there is no cost to lying as long as they get their fix; in the group, however, they suddenly discover that the cost of lying both to themselves and to others is enormous (Wenger-Trayner, 2017). Commitment to the regime of competence of the community thus increases the cost to oneself of lying. And lying is a possible precursor to relapse.

13.7.3 Respect

Respect for others in word and deed is important in the practice of addiction recovery of this study. Respect for others takes various forms, such as being on time for the group. The following quotes show how far the participants had come from their addiction lifestyle:

It pisses me off when people come late — especially, the inpatients. — Karen

Disrespect for time. Because in your recovery you need to learn to respect time, 'cos you never did that before. — Jashwin

Keeping time is about being where you are supposed to be and doing what you are supposed to be doing. It is also about keeping one's word. Support and therapy groups typically have a rule about punctuality; it promotes mindfulness and accountability to self and others around the commitment to time.

Arguably, the core of behaviour change in a recovering addict can be seen in the respect the person now has for herself and for others, in contrast to the disrespect displayed before she began recovery. Regardless of whether one agrees with someone or not, the group encourages participants to listen and confront kindly, with the recovery of the individual, the other members of the group, and the practice of recovery, in mind.

Jashwin commented on this:

> *Respect and tolerance all add up to accountability. And accountability is huge in the group as we owe it to one another by our actions. And we account for our words and our actions that keep the group going. For example, giving your word and keeping your word is one of the things. Having people be able to count on you. And maybe you keep your word more here because it has a different meaning here. Because where it concerns my recovery, it is not negotiated. Because recovery has to come first. And if it's not taken seriously it could hurt the family.*

The use of the word "family" by Jashwin and other participants to refer to the group highlights the members' importance to each other and sense of kinship. They were vigilant with each other, tracking days of sobriety, accounts of recovery and narratives of life in general — in part, because of the great bond they had with each other, composed both of affection and attachment. They had put themselves in each other's hands, as far as their recoveries, wanting the best for themselves and each other. This gave them the right to challenge each other, as each was accountable for not only his or her own recovery, but also for how that might impact on the others. The idea that 'we are only as strong as our weakest link' was brought up often in the group; building each other up with kind confrontation thus assisted everyone.

Vega gave an example of lack of accountability:

> *So if someone gives their word here, and doesn't keep it, it means they still have some distance to cover in their recovery. And it's important because if they break their word here, for example, by saying they are coming and they don't, it means to the group: when can we count on you and when can't we? It makes things unsure again — like in addiction.*

The bond of trust in a recovery group is both deep and delicate: when someone is depending on another person and is let down by them, the person experiences betrayal and doubt and insecurity sets in, which can contribute to a relapse. Some participants commented on this:

> *It's extremely disappointing. — Vega*

If you agree on a time and then you don't keep it, it's just not the right thing to do. It's not being accountable. And that happens in your outside life — if you can't be trusted in here, then you can't be trusted there. If you said you would be here, and you aren't, then how do you even explain it to yourself first that you aren't where you said you would be? — Jashwin

If people say they are going to be here and they aren't, then it sets the group back. It speaks to honesty and dependability. — Nikhil

The pain, frustration and disappointment in these comments is tangible, underscoring the importance of being a person of honour and integrity as the aspirational outcome of the practice, for the benefit of both the individual and the group.

13.7.4 Accountability in the case of relapse

The event that all addicts try to avoid is relapse. However, it does occur — often, and for many. Karen went through rehabilitation eight times before she was finally ready to commit to sobriety — learning something new along the way and consolidating herself further each time. Stephen, one of the addiction counsellors, explained that relapse should be taken in one's stride:

So, in a group, right from the start, we need to tell people that if you do relapse, don't beat yourself up, just come to the group because we will welcome you back and that there's nothing to be ashamed of. All it means is that you need to use it as a stepping-stone and learn from it. And if you can learn from it, then relapse is a good thing.

Relapse creeps up on an addict when he loses the vigilance he has gained in meetings. Spero clarified:

I am ok if I skip a meeting; but if I skip two, I can feel the wrong sort of self-confidence and I know it is the beginning of a relapse.

In other words, awareness and vigilance of the self are crucial in recovery as one's blind spots return. Because relapse actually begins long before the action of picking up the drug or drink, regular group attendance is vital.

Vega expressed how the accountability the practice provided played an important role in her avoiding relapse:

> *I've made myself accountable to the group and I'm pretty sure it's that accountability that's kept me clean for as long as I have been* [over four years at the time of this interview]. *I've made myself accountable by not letting the group down. I don't want to come in and say that I've relapsed. So, having that accountability helps me because I'm going to be wrecking my life if I relapse. ... I stay clean for other people too in the group and if I didn't come here and I relapsed, who would notice? It's one hundred percent. When I came back, I was on the verge of relapsing. And I think if I hadn't come back and got the support of the group, I would have relapsed and that would have been the end of that — of me. And now I've gotten to know everyone, and I've made the choice to be accountable to this group and its people. It came about over time that I saw I was part of this. For me this is a really special group. Also, to just honour the group —by staying clean.*

This underscores how recovery is a personal choice for a person with addiction and the lengths to which an addict may have to go to maintain her sobriety. For Vega, this included making herself accountable to the group, which she honoured by not relapsing.

For Jashwin, the group provided a space that allowed him to vent honestly, clearing his emotion from the week and gaining support from others in order to avoid the possibility of relapse:

> *If we have had a bad week, it allows us to share and to take the support from the group. It's a place where you can open up and share and you know that there are honest people who want to support you and want the best for you and you can trust them and count on them.*

On the topic of how the group would have responded if a member had relapsed, Vega commented:

> *If I relapsed, the group would be disappointed, but they would still be welcoming, if I was honest.*

In other words, there would be a place for her and forgiveness because she was still displaying honesty and contrition — characteristics of a good person, wanting to own up and make recompense. The group therefore had fail-safes: members could make mistakes, but as long as they returned to the group with a sense of contrition and willingness to take responsibility and learn from the relapse, they would be welcomed back.

Jashwin took a clear line on this:

> *The group would continue, but you would have to earn your place again. You'd have to fix up the lies and the things you knew you had done wrong — that you had deliberately done or said — because it hurt the group. If you want to be in the group, and you stayed in the group — it's like me finding out that my wife was having an affair — that's how it hurts. Because you are with this person for years, you trust one another, you talk a lot of confidential things to one another, and you share — only to find out that the person was never honest all the time. You lose faith in a member of the group; you lose trust. And that trust needs to be earned again.*

Here we see that he, too, would have been ready to forgive, but had learnt to not enable destructive behaviour but to be assertive and clear so that the transgressor could make proper amends and have the opportunity to put things right. The group was open to those who wished to be part of it — but the practice was open to those who wanted to take responsibility and make amends, growing into a better person. Because it is that better person who is less likely to relapse and, if she does, is more likely to return to the group and continue the identity work involved in addiction recovery.

13.7.5 Each recovery is different

On the issue of identity and accountability, Farnsworth et al. (2016) noted:

> [I]f the practice has a narrow accountability so much that people have to almost forget who they are in order to belong there, the experience will not transfer into

> the rest of their lives. It's like clipping the wings off a bird and wondering "Why isn't it flying?" You clip people's identity to a point that there's only the right answer, only certain very narrow ways that count as competency there. (p. 155)

This quote speaks to flexibility and uniqueness — encouraging the idea that each recovery is individual in the group, yet observing accountability when important lines are crossed. Two members of the group with contrasting philosophies about recovery noted this. Mervyn, one of them, explained:

> *As you know, I've spoken to others about my process of early healing — staying in the house, hibernated and cocooned myself — and then the other person says for him, he had to go to bars and face his demons — go into the lion's den. So, we have both different opinions of recovery. Recovery is a personal choice.*

This example is of how two participants had recovered using apparently opposing approaches to recovery. The underlying point is that each person needs to find the way that is right for them — and this involves the cultivation of a new identity within the practice. Stephen said: "It's about learning to live the best life you can in every way"; while Bob said, "Because everybody's story is different". This stands in contrast to the AA model in which recovering addicts aim to be able to tell the same story in order to earn full membership. Both are successful recovery practices.

Being able to tell one's own story of recovery was considered a competency in the practice. Stephen described how he saw this:

> *I am inspired by how each person does it in their own way. There are similarities, but each does it in their own way. And with each addiction, people like to lump alcoholics [together] because there are similarities; but I think each one of our addictions is very unique — very personal — to us. We follow the same pathway but our recovery is unique and is our own.*

Clearly, it is essential that an addiction recovery group strike the right balance between accountability — holding the participants to a code of behaviour — and providing the flexibility to allow each person his or her unique path of recovery.

13.8 CONCLUSION

In this study, the concepts of a competency framework and a regime of competence were applied in order to deepen the understanding of how addicts learn socially within the community of the recovery group. Membership and accountability were found to be key aspects of the group's regime of competence, which, with the competency framework, made a living path of learning to recover through members' joint and individual journeys.

This chapter has described how learning transforms identity and is located within the participant as a social participant in a network of relationships within a particular practice. Learning is not only about acquiring certain knowledge (a framework of competency) — as was evident in the findings tabulated in this chapter; it can be considered a form of curriculum which was developed over time by the members of the recovery practice. Recovery practitioners practised these skills and used the conceptual tools regularly, integrating them over time. Learning is also about becoming a specific knower in a context where what it means to know is negotiated with respect to the regime of competence of the specific community of practice; in this case, the addiction recovery group. In this manner, the total personal transformation of the addict and his recovery maintenance within the practice is manifested. The different layers and levels of knowledge needed over time, as well as the significance of membership, the regime of competence, accountability, honesty, the uniqueness of recovery and the handling of relapse emerged and were discussed.

This chapter has presented the findings of this study related to the research question regarding what knowledge assists participants to maintain their recoveries.

CHAPTER 15
CONCLUSION: STAYING ON THE WAGON[4]

This concluding chapter summarises the key findings of this study. The study explored how addicts learn to recover in an addiction recovery group: firstly, by identifying what the group mechanisms are that assist in the maintenance of recovery; secondly, by identifying the pedagogic processes occurring in the group; and thirdly, by discovering the knowledge which helped participants to maintain their recoveries. These accomplished objectives are summarised in this chapter. This chapter includes suggestions for future research and closes the thesis with some concluding remarks.

14.1 STUDY CONTEXT AND BACKGROUND

This particular study took place in South Africa. Key aspects of this context were discussed in terms of how addiction is an ongoing and critical problem ranging across economic, cultural, gender and racial lines, with insufficient resources provided by government to tackle the issue and adequately provide treatment for those who are unable to afford it — particularly for addiction aftercare. This highlighted the need for an intervention that was workable and cost-effective for the recovery population.

The efficacy of group work in the field of addiction recovery was introduced with a discussion of the psychological group work model and twelve-step approach. Twelve step groups were shown to work because they enable being and feeling part of a community that is committed to the same goals (of not returning to the addictive substance and of building / creating a good life). This in turn enables a culture of honest friendship and accountability, within which participants can both recognise one another's growth and call each other out when they can see the possibility of a regression. This ongoing meaningful companionship, coupled with human connection and the ongoing learning

[4] Being 'on the wagon' is a term commonly used to refer to being in recovery. It was used often in the group and is used as part of a graphic metaphor for the findings presented later in this chapter.

within it, giving the participant tools to manage triggering emotions, overcomes the need for the substance.

Yalom's (2005) curative factors in group work were also linked to addiction recovery. Literature indicated that participation in a recovery group impacted positively on recovery. Much of the research cited focused on twelve-step findings, as these groups have proven effective and exist around the world in diverse communities; as they are peer-led and run on a donation-only basis, so they are also cost-effective. As such they, and similar models, are ideal for the South African context.

Research on the aetiology of addiction originating in problematic early relationship was introduced, highlighting the prevalence of trauma, mental illness and other problems among the addicted population. Khantzian's (1987, 1990, 1997, 2003) self-medication hypothesis illustrated the attempted solution that the addict seeks — largely in replacing the positive functions of relationship (such as consistency and soothing) with their substance of choice. Psychoanalytic explanations were provided for addiction and group recovery was described as a way out of the destructive nature of addiction.

Redemption and reparation through relationship via group social learning mechanisms was discussed. For those who commit to recovery, this study found that participation in a group offers a stable, welcoming and positive alternative to addiction, and an addiction recovery practice was seen to provide a viable pathway out of addiction and a means of transforming the person of the addict and her life for the better.

While Hari's observation that "the opposite of addiction is human connection" (Aitkenhead, 2015, para 6) sums up the importance of the social learning aspects of recovery, communities of practice theory (Lave & Wenger, 1991; Wenger, 1998b) provided the conceptual tools to thoroughly investigate and analyse the mechanisms at work in this type of learning. This is underscored by addiction neuroscientist Judith Grisel (2019), who believes that the way forward regarding addiction and recovery does not lie primarily in manipulating DNA but in encouraging human love, compassion and connection. Grisel (2019, para 16) holds that while we need a range of tactics to tackle the global problem of addiction, "the people right next to us are an obvious place to start. Human relationships and connections are the low-hanging fruit".

However, it is a particular type of relating that is present in the recovery group, the nature of which was revealed through the interdisciplinary lenses of the present study. Participating in the group and adhering to its various modes of relating enabled addicts to further their mastery of addiction recovery and transformed various aspects of their individual identities — psychological, spiritual and physical. Without this transformation there could have been no recovery; in turn, the motivation they achieved from their progress with recovery boosted ongoing transformation.

By understanding the pedagogic mechanisms which facilitate the transformation of participants from a using to a non-using state, and the factors which maintain their recovery, this thesis makes a unique contribution to the existing body of knowledge related to addiction recovery. It also contributes to the field of addiction recovery in South Africa. In addition, it contributes to the extant body of knowledge on the social learning of recovery from addiction, particularly communities of practice theory. It also makes a contribution by using the bricolage method — as seen in the creative approach of the thesis structure division into two main parts and the situating of each main finding in its own literature review.

14.2 SUMMARY OF FINDINGS

Using the bricolage method, the following study has brought a range of findings from different approaches together into a ‘quilt’ or ‘stained-glass’ presentation. Each piece is unique and self-contained, yet also fits together with the other pieces to make a whole which is greater than the sum of its parts.

The metaphor of the wagon in the diagram in Figure 14.1 below summarises the findings and brings key aspects to the fore. The process of recovery begins with the individual taking the first step to committing himself or herself to the group or practice in order to recover. They have to get ‘on the wagon’.

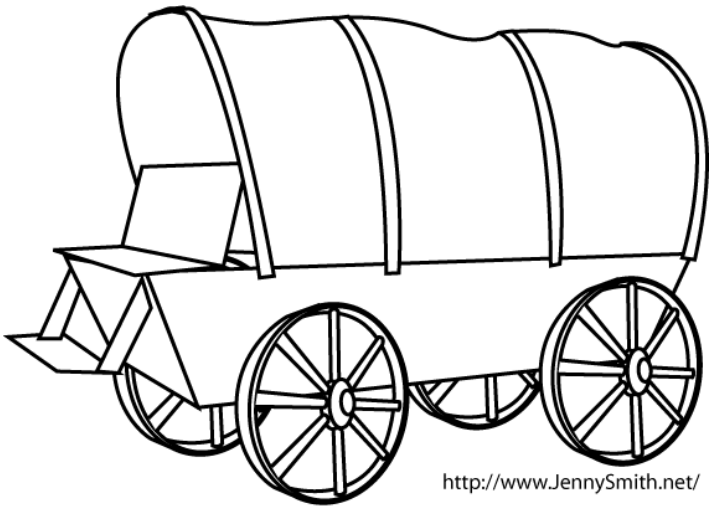


Figure 15.1 A wagon, representing the journey of recovery (Smith, 2012)

The wagon provides a useful metaphor for recovery and for the discussion of the findings of this study. The canvas stretched over the wagon provides protection from the elements as well as safety for, and storage of, provisions for the journey. This is representative of the containment, belonging and security provided by the physical location of the group in the clinic premises, where the participants all began their recovery journeys; of the physical and non-physical artefacts that are part of the recovery practice; and of the containment of the group in time and space. The wagon, like the group, provides an ideal vehicle for the recovery journey.

Also, the wagon has four wheels — each providing stability and functionality to the wagon. The wagon cannot move without each wheel being in good working order. The adaptability of the four different elements of the findings are like wheels which must be able to roll and withstand various terrains, and yet firmly keep their place, in order to hold the wagon on the road.

14.3 THE FOUR WAGON WHEELS MODEL OF RECOVERY

The ‘wagon wheels’ diagram in Figure 14.2 illustrates the four elements (‘wheels’) on which recovery relies and the interrelationships between them. Each element is developed

through, and impacted by, the other elements. The arrows in the diagram indicate that these processes happen simultaneously and are mutually influencing.

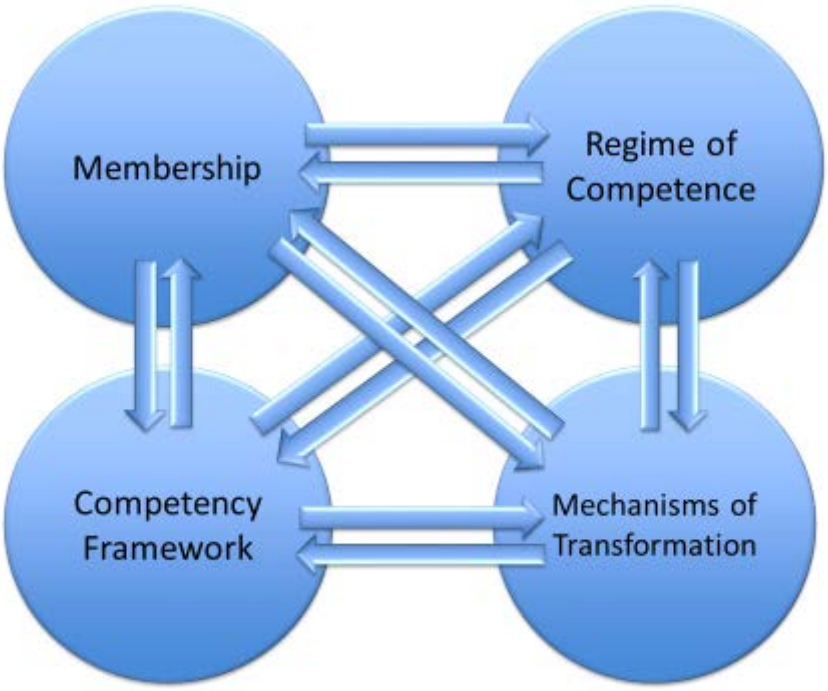


Figure 15.2 The 'four wagon wheels' model of recovery

Some aspects appear in more than one element but mean different things in each specific wheel — such as honesty. In Mechanisms of Transformation, honesty is an emotional capacity which builds a better person; in the Regime of Competence it indicates that something critical has been transgressed and that relapse may have happened or be likely to occur; and in the Competency Framework it indicates skills (such as paying debts) which enhance the member's recovery repertoire. Should the participant not adhere to each of the four elements, or the group not provide them, then recovery will not happen as fully as it could. There may even be relapse. All four wheels work together in order to keep recovery going. The wagon, like the group, needs to be robust enough to endure over time and fulfil its function.

14.3.1 Membership wheel

Figure 15.3 The membership wheel as a key aspect of recovery

The first step of learning to recover is to become a member of a recovery group. The findings of this study show that membership in a particular group, or practice, focused on addiction recovery was important. As discussed in the previous chapter, there are various aspects and types of membership (full, peripheral and marginal). In order to fully benefit from the recovery group, one has to be a full member. The trajectory of this membership moves from peripheral to central and full over time and through participation.

Full membership included regular participation in the group, and this supported research regarding the effect of regular participation in an addiction recovery group, which was more fully discussed in the literature review (Connors, Donovan, et al., 2001; Gossop et al., 2003; Gossop et al., 2008; USSAMHS, 2016). Membership included exposure to and identification with role models as well as providing this for newcomers. This aspect of membership is seen in work by Emrick and Tonigan (2004), Humphreys, Mankowski, et al. (1999), Humphreys and Moos (2001), Humphreys et al. (1997), Humphreys and Noke (1997) and Kelly et al. (2009).

The experience of being a member offers the participant acceptance and belonging — vital when moving out of addiction and an addicted network into a new social and personal way of being. Participants referred to each other often as "family" and this indicated the depth of the bond they had with each other. This bond allowed the group's social learning to occur as it embodied trust, belonging, familiarity, respect, acceptance and credibility.

14.3.2 Regime of Competence wheel

Figure 15.4 The Regime of Competence wheel as a key aspect of recovery

Another of the four core wheels of group recovery maintenance is the Regime of Competence to which the participant is accountable. This allows members of the practice to call each other out on any slippage, distractions or transgression regarding the practice that was developed in the recovery group. This is critical in terms of relapse, which begins in the head and behaviour of the addict (e.g. missing group, turning up late) before it manifests in the consumption of the addictive substance. For the Regime of Competence to be effective, there need to be foundational aspects in place, such as trust, acceptance, confidence, openness, genuineness and respect, among participants. These qualities

predicate and are part of social learning, and thus the Regime of Competence is closely bound to these aspects of membership.

Participants become members of this new practice of recovery through a process of participation over time. As members adhering to a developed set of expectations and criteria within the practice, they gain access to the social history of the practice's learning and understandings of 'competence'. Within the practice, the notion of competence is both dynamic and contestable.

The Regime of Competence holds participants mutually accountable to their recovery practice. This is particularly important in an addiction recovery group as the work of recovery can make the difference between life and death, and during addiction addicts are dominated by their addiction and are accountable to no one. Establishing accountability outside themselves is of critical importance, then, in recovery.

Criteria for this Regime of Competence included honesty (not lying to the group), authenticity (not trying to impress by lying), accountability, respect (keeping one's word and time), and accountability in the face of relapse. Group members could call each other out for not adhering to any of these as this would signify that a relapse could have happened or could be likely to happen. Displaying these qualities also indicates reliability of the member and someone one can trust through one's recovery process.

This aspect of group recovery is critical as the members trust each other and will listen to what the other says in a way that they will not listen to anyone outside the group. Participants are thus able to call each other on the 'blind spots' they notice, and this builds up both participants. Should this not exist in the group, or should the participant not respect and work on what she is being called out on, it will clearly lead to problems with their recovery. It takes courage to call another member out for a challenging behaviour, and if it happens it shows the personal growth of the one doing it, as well as his good intentions toward his fellow addict. This indicates a link between the Regime of Competence and self-esteem, which is part of the Mechanisms of Transformation.

The group needs its members to participate if it is to have the capacity to effect change in its members, and the individual members need the same thing. Hence, a member challenges another member not for the sake of that member only, but for the sake of the group and him or herself.

14.3.3 Mechanisms of Transformation wheel

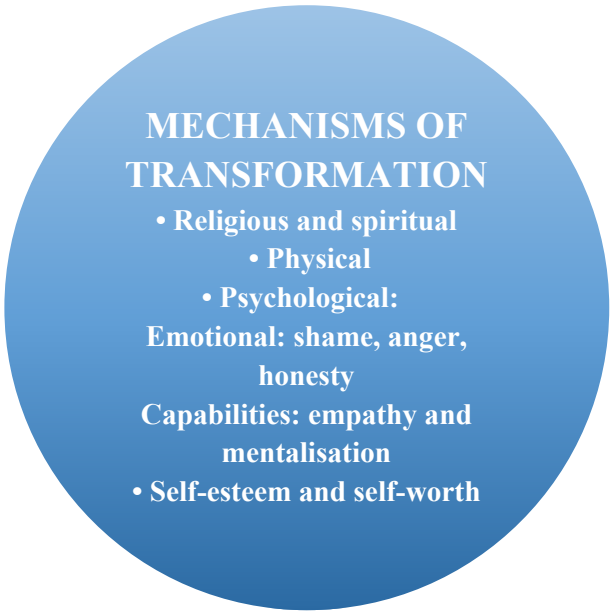


Figure 15.5 The Mechanisms of Transformation wheel as a key aspect of recovery

Membership and belonging to this practice influence the transformation of the identity and self of the participants. These personal aspects were termed Mechanisms of Transformation in this study. Because significant aspects of a person are involved in addiction and addiction recovery, participants learn, understand and work with different aspects of themselves — their spiritual, physical and psychological (which includes honesty, shame, guilt, anger) aspects — and cultivate empathy and self-esteem, which build the resilience of the self in the face of relapse.

By continually attending and participating in the group, capacity is continually being built within the individual for recovery and its maintenance. At the same time, capacity is being built within the practice. The support and knowledge from others on the same path and identification with them is vital, bringing hope, knowledge and confidence.

The view that each person must recover in his or her own way was held as an operating principle above all others. At the same time, capacity was developed within the practice of recovery, which in turn enriched members. Not all the criteria in this wheel applied to

everyone: for example, not everyone had issues with anger or was religious or spiritual. This mechanism embraced the individual nature of the participant.

Each individual also needed to learn better and different ways of coping with challenging emotions (anger, shame and lying) and to move from being selfish to developing ways of considering others, such as building mentalisation skills and empathy for others. These aspects facilitate the addict's personal growth and move her away from the narrow habits of addiction to broader and richer ways of life.

Setting goals and reaching them builds self-esteem and this is linked closely with the Competency Framework, which includes the mastery of a variety of recovery skills.

14.3.4 Competency Framework wheel

Figure 15.6 The Competency Framework wheel as a key aspect of recovery

Within the communities of practice conceptualisation, because knowledge is reified from participation and is contestable and dynamic over time, the Competency Framework described in this study is a work in progress. The group itself defined and developed a framework of recovery competencies which are listed above and were considered as fundamental to the first year of recovery.

This is a curriculum of this group's recovery. Each competency needed to be developed and this does not happen at once but emerges at different times in order for recovery to take place and to sustain itself. These skills, which are implemented daily, facilitate the individual's moving from a substance using to non-using state and to being in recovery and living a life of their own choosing. The addict journeys day by day through the various landscapes of life on the wagon of recovery.

While there is flexibility in terms of when one masters these skills and which competencies one masters, by the end of the year all participants had mastered or were on the way to mastering them all. Breaking denial, however, was found to be a prerequisite to the others: it has to be achieved first or there can be no recovery. The remaining competencies are there to assist with recovery. Everyone in the focus group practised these competencies and built up their recovery repertoire and capacity. Failing to practise certain competencies, such as awareness of triggers and planning each day, is likely to cause the addict to relapse.

Thus, the mechanism is such that when the addict is beginning to veer into harm's way in terms of relapse, the Regime of Competence emerges. Otherwise, there is a lot of flexibility and latitude in the connection between these two wheels of recovery.

14.4 MOVING FORWARD IN RECOVERY

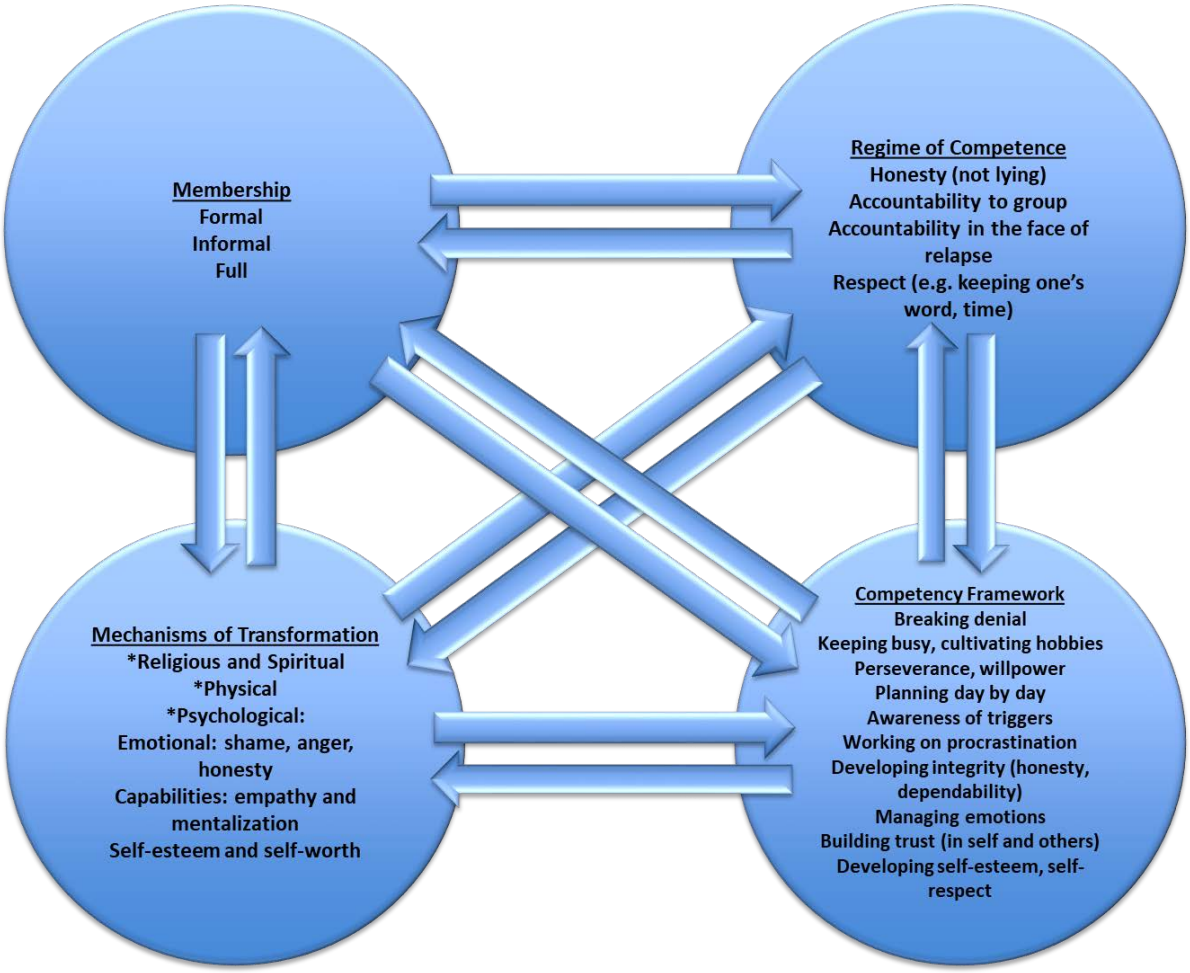


Figure 15.7 The complete 'four wagon wheels' model of recovery

In this model, the complexities of group addiction recovery are made manifest. There is much that happens in each session in the group, and over time, from which the addict learns recovery. The following section describes some of the interrelations and interactions within each wheel of recovery and between them.

14.4.1 Time in the recovery group and the recovering member

As recovery is a process, time is a critical aspect which impacts on each of the wheels of recovery. Membership is based on the trajectory of moving from being peripheral to full and being accorded that status by the group because of performance in and commitment to the group over time. Time plays another role in the group — namely, in the development of a recovery repertoire in the Mechanisms of Transformation and Competency Framework. Both of these are linked to the Membership of the individual as they develop and exhibit their recovery repertoire and commitment to the group over time. The significance of this is that the group would respect someone who has relapsed many times but keeps returning to the group to learn more as much as they would respect someone with a long and unbroken recovery record.

14.4.2 Interrelations between the wheels of recovery

The four wheels of recovery work together and separately, and the addict needs to be open to the different aspects of each to ensure the best chances of sustained recovery.

14.4.2.1 Membership and the Regime of Competence

The Regime of Competence emerges from member participation. It is the way that practice members acknowledge Membership by the display of the behaviour and criteria that emerge from a particular practice that members have defined as competence. These two wheels of recovery are tightly linked and mutually reinforcing. The Regime of Competence can be seen to emerge from Membership.

14.4.2.2 Membership and the Competency Framework

The Competency Framework is a way of turning the practice into the curriculum. Here it becomes tangible and inspected. Members benefit because they have a common language and approach to recovery through the Competency Framework. Mastery enhances

Membership, and Membership supports and provides a path for the Competency Framework.

14.4.2.3 Membership and Mechanisms of Transformation

Membership provides the participant with the opportunity to learn how to recover. The addict participates, gaining credibility in the eyes of others in the group over time by exhibiting mastery in the traits, qualities and criteria of the other three wheels of the recovery model. The relationship between Membership and the Mechanisms of Transformation is that the group offers a physical and emotional solution to many of the challenges of recovery. Examples are shame, where the addict is accepted warmly and intimately among a group who share this emotion; opportunities for honesty, such as when sharing how many days one has been clean; and being able to talk and learn from other members about challenging aspects of recovery that impact them personally.

14.4.2.4 Mechanisms of Transformation and Regime of Competence

Within the Mechanisms of Transformation, much regulating within the person of the addict takes place. Experiences of shame and anger, for example, which could cause the addict to leave the group or relapse, are met with empathy and identification from others, which are then internalised by the person of the addict. All these are found within the Mechanisms of Transformation. Here the group assists the addict to rework his or her emotional responses. The experience of deep acceptance and empathy, and modelling of alternative ways of being strengthens the addict's recovery and commitment to the group.

Empathy and understanding are also vital when relapse is confessed, and this happens in the interplay between Mechanisms of Transformation (empathy, forgiveness, and acceptance) and Regime of Competence (transgression that needs to be accounted for). This interrelationship provides a powerful harmonising between two opposing forces in the group and in the recovering addict.

Within this, Membership holds strong in terms of group rules — starting and finishing time, for example. This is vital for the containment of the relapsing addict and the group

— and the containment of time and Regime of Competence are at their strongest at the time when the relapsed addict is at her most vulnerable (often most emotional) and members are pushed to extend the group time. Here, Mechanisms of Transformation and aspects of Membership are challenged within each member, who is torn between compassion and empathy, on the one hand, and boundaries (Regime of Competence), on the other. The operating principle always is to put one's own recovery first.

Another tension between these two wheels of recovery is that within the Mechanisms of Transformation not all criteria applied to all members (e.g. not all had anger issues or were religious) — this allowed for diversity and inclusivity within the group. However, in the Regime of Competence, the criteria applied to everyone and each member could be called out on erring on any one of them. This indicates the importance of both mechanisms in recovery. Also, here the Regime of Competence will emerge strongly when it appears that the addict is putting themselves in line for a relapse. This works very similarly to the following relationship between the Regime of Competence and the Competency Framework, as shown in the following section.

14.4.2.5 Regime of Competence and the Competency Framework

The strength of the link between the Competency Framework and Regime of Competence emerges when the addict is moving into harm's way (relapse). It is only then that the Regime of Competence would exert influence, as recovery is predicated on the breaking of denial, or knowledge of triggers or good planning (all found within the Competency Framework), for example. Group members are aware of when things become dangerous for the participant and call them on it very quickly.

Most of the competencies, while helpful in assisting with recovery, are not critical if not practised. Thus there is flexibility and latitude in the relationship between these two recovery wheels.

14.4.2.6 Competency Framework and Mechanisms of Transformation

The Competency Framework incorporates the skills which emerged from the practice and were considered by the members to be essential to recovery. These are practised daily and, as with any skill, improve and build towards confidence and competence in recovery in the participant. These skills are what most members of the practice would be mindful of on a daily basis and attempt to address in their recoveries.

The Mechanisms of Transformation relate to specific aspects of the identity and person of the addict, which are transformed via participation and practice. The relationship between the Competency Framework and Mechanisms of Transformation is that by setting goals and meeting them, the participant can build self-esteem and self-confidence which then can assist in developing overall recovery capacity. This provides much motivation for recovery and for embracing the Competency Framework. They work together, strengthening the learning of the addict to build up the repertoire of skills in different areas that build recovery capacity.

14.4.2.7 Regime of Competence, Competency Framework and Mechanisms of Transformation

The Competency Framework and Mechanisms of Transformation function by offering ways to take the addict out of her old ways of being and transform her. Through participation she has changed her life on a daily basis, opened up possibilities and meaning, boosted her confidence and self-esteem through mastery of the skills in the Competency Framework, and learned adaptive ways to deal with key aspects of herself as a person. The addict has latitude over her practice of the competencies that she learns in the group — until she seems to be deviating off her recovery course — and then the Regime of Competence begins operating strongly: challenging her, pointing out where she is erring and ensuring she is back on course again. This underscores the importance of honesty, which features in three of the wheels of recovery.

14.4.2.8 Membership, Regime of Competence and Competency Framework

The Regime of Competence and Membership have a close relationship: Membership embodies acceptance, trust, belonging and respect while the Regime of Competence exposes transgressions of the emergent practice of recovery. Both are critical in terms of holding the participant accountable to their recovery and can be said to play 'good cop, bad cop' roles together.

The addict begins learning to recover from engagement with the Competency Framework. The practice of these skills gives the addict confidence in her mastery and she builds her repertoire, deepening it by embracing personal aspects of change through those embodied in the Mechanisms of Transformation.

The 'good cop, bad cop' functions embody the parenting ideal: containing, soothing, nurturing, and encouraging — while also firm, disciplined, protective and moral. By participating here, the addict internalises these functions for herself, while transforming herself through the Mechanisms of Transformation and Competency Framework over time, and ceases seeking for them in addiction.

14.4.2.9 Regime of Competence, Membership, Mechanisms of Transformation and Competency Framework

The Regime of Competence plays a vital role for the participant in the practice of recovery. Without an authority or power aspect to the group or practice to draw attention to transgressions of one member by another, the group and its members would fail. The function of this wheel is to preserve the group as a place that is safe and credible to learn recovery in, as well as to keep participants accountable. As such, it works closely with the Competency Framework and Mechanisms of Transformation wheels.

The operating principle of each person being able to recover in his or her way adds a flexibility and freedom to the recovery of each person and the pedagogy that emerges; however, it requires strength in the Regime of Competence to be able to hold the different paths of recovery. This comes from participants having integrity — which means that they would have to be old-timers to have developed this. It also means that there is an

attitude of openness to learning and changing for the better in the group that the newcomer feels from the start. Mutuality is essential here which is why this aspect works.

Each of the four wheels is vital to the recovery process. Membership is more foundational than the Regime of Competence. Once a person becomes a member, they begin learning the basic skills of recovery as these are tangible and immediately accessible — the Competency Framework offers them this. The Regime of Competence is always there to keep participants in line, watch their 'blind spots', and hold members and the group accountable. It is here that members learn what not to do and why not to do it. The Regime of Competence provides a protective function by exerting authority in the practice, keeping the practitioner on the wagon in the face of imminent relapse.

However, the reason members came to the group in the first place was to change — and so the Regime of Competence and the Competency Framework lead directly to the Mechanisms of Transformation. It is here that the member transforms the major personal aspects of themselves, because the mechanisms required to do this and keep them in recovery are within the Mechanisms of Transformation. Changes which take place in the person themselves through practising the skills of the Competency Framework and working on aspects of the Mechanisms of Transformation motivate recovery. Without the tangible changes in the person at the physical, emotional, cognitive and (if important to them), spiritual and religious levels — and the acknowledgement of these by others as well as by themselves — the motivation for recovery would fall away.

At the same time, there are interrelating links between the Mechanisms of Transformation and the other three wheels as old-timer members comment and share, referencing their knowledge and experience from the other wheels of recovery. The Mechanisms of Transformation depend on the Competency Framework, as mastery of these skills impacts and influences changes in the member — such as the development of self-esteem after achieving goals set over time that originated in the Competency Framework.

The mechanisms of the four wheels interrelate while driving recovery forward. In this way, the wheels can effectively deal with challenges on the rocky road of recovery.

14.5 CONCLUDING REMARKS

"The right way to wholeness is made up of fateful detours and wrong turnings."
— Carl Jung (in Stein, 1999, p. 184)

This study has shown how addicts learn to recover in an addiction aftercare group. It has highlighted the total transformation that the person of the addict undergoes when in recovery, and the mechanisms involved in this transformation using a group process. Ultimately, the findings of the study highlight that this transformation is possible and achievable through committed participation. This adds a powerful weapon to the arsenal in the 'war on addiction'.

As a witness to such transformation, I have found it inspiring to see how, through something as simple as regular participation in a group, committed people who are on the same road and want the same thing, can transform themselves and each other so profoundly.

Umuntu ngumuntu ngabantu.

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APPENDICES

APPENDIX 1: PARTICIPANT INFORMED CONSENT FORM

Dear

Consent to participate in study on how addicts learn to recover through participating in an aftercare recovery group.

My name is Margot Sennett Freedman, and I am registered for a PhD in the School of Education at the University of KwaZulu-Natal (UKZN).

I am conducting a study on how addicts learn to recover through participation in an addiction aftercare recovery group.

This study aims to explore:

1. To examine how participants in the addiction recovery group learn to recover;

1.1. To identify what in or about the group assists in the maintenance of the recovery of regular participants in sessions as well as from session to session;

1.2. To explore and identify what processes of teaching and learning take place in the addiction recovery group;

1.3 To discover what knowledge assists participants maintain their recovery.

You have been a participant in the XXXXX Addiction Aftercare group. I would therefore like to ask to you consider taking part in the study.

The study methods include:

- Attending at least one individual interview with me (approximately two hours in total).
- Attending a focus group discussion, with other group members, where the role of the group in your recovery and your learning to recover will be discussed (approximately two hours).

These activities will take place at XXXXX Clinic at mutually convenient times, but in a venue separate to the one where the addiction aftercare group is held, to denote a difference between the therapy group and this research and in my role changing from health provider to researcher, and your role changing from recovery group client to research participant. This is only for the duration of the research.

The following points are also important to note about this study:

- The activities will be audio-recorded and saved in electronic format. These audio-clips (and any transcriptions and documents that arise from these) will be securely kept by me and then my supervisor for the duration of the study. I will then dispose of these five to seven years after the study has been finalised.
- Any information you disclose will be kept confidential, and your identity will also remain anonymous.

- Your name (and any other identifying details) contained on any documents you produce or are produced during the data production process will be replaced with a code or pseudonym. Myself and my supervisor will be the only people who will be able to match the code or pseudonym back to you (the original data source).
- Involvement in this study will pose no financial cost to you. Should you need to travel anywhere for the study, these costs will be covered by me.
- It is possible that study participants may feel some discomfort or stress from the study methods. Study participants do not have to answer certain questions if they choose not to. Should the research process upset you in any way, a list of referral resources will be provided for you.
- Your participation in this study is entirely voluntary, and you are free to decline to take part or to withdraw your participation at any stage should you wish to. Your withdrawal from the study will not disadvantage you in any way. In addition, your participation (or choice of non-participation) will not influence your continued participation in the recovery group in any way whatsoever.
- Should you wish to answer in a language other than English, a translator will be provided for you.
- Should you wish to participate in the study, but would prefer to be interviewed by someone other than myself, a different interviewer can be arranged for you. This may be regarding questions such as what you learn about recovery from the psychologist , which you may feel awkward answering. The point is to feel as free and unedited as possible during the data generation (interview) process.
- Involvement in the study may hold out some possible benefit to you by providing an opportunity to reflect upon the activities of your recovery, however any direct personal benefit from the research cannot be guaranteed. The benefits of the research lie in the knowledge to be gained from it for the future.
- The results of the study will be disseminated to you via a specially convened meeting.
- My research supervisor is Professor Wayne Hugo , and he can be contacted on hugow@ukzn.ac.za or 033 260 5535 should you have any questions regarding the study, or your involvement in it or HSSREC Research Office, Ms Phumelele Ximba, Tel: (031) 260 3587, Email: ximbap@ukzn.ac.za or Ms Mariette Snyman, Tel (031) 260 8350, email: snymanm@ukzn.ac.za

The study has received ethical approval: Number: HSS/1230/014D

Sincerely. 

Margot Sennett Freedman (Ms)

Tel: 033 260 5734,

Cell: 0835629789,

Email: sennett@ukzn.ac.za

Consent to participate in study on how addicts learn to recover through participating in an aftercare recovery group

I…… …… …… …… …… (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. Activity	Consent to Participate ✓ if yes	Consent to Tape Record ✓ if yes	Fieldworker – I State language and if you Tick if Required I would like a translator
			I
Individual Interview			I
Focus Group			I

You may write "NO" if you do not wish to participate in any of the above activities.

I understand: ……. Tick	I
That I am choosing to participate in a research process looking at how addicts learn to recover in an addiction recovery group.	
That in this research process (which consists of an individual interview and a separate focus group) I have the choice to opt out at any stage	
That I have the choice to have my data withdrawn if I notify the PI (primary investigator) timeously	

That should I wish to be interviewed in another language; a translator will be found for me.	
That should I agree to be interviewed by the PI, (primary investigator) who is also the psychologist who facilitates the addiction recovery group run at Akeso Clinic, no specific benefit will accrue, nor prejudice befall me.	
That should I agree to be interviewed by the PI, who is also the group psychologist, she will be functioning in the role of researcher and not recovery group facilitator.	
That should I agree to be interviewed by the PI, who is also the group psychologist, my role will change to that of research participant and I will be interviewed on my learning of recovery through the group.	
That I have the choice to be interviewed (in either an individual interview and/ a focus group) by another interviewer who is not the PI/ group psychologist, and if so this will not prejudice me in any way	
Should I wish to change interviewer at any stage during the process, it is my right to request this change (between PI and fieldworker).	
If I choose to be interviewed by the PI, who is also the group psychologist, my role will change to that of research participant and I will not be a recovery group client at that time (individual interview and/focus group). I will be interviewed on my learning of recovery through the group.	
This means my role will be as a research participant to assist in the data collection on the phenomenon of learning to recover from addiction in a group. The fact that my group psychotherapist may be collecting that data is incidental.	

SIGNATURE OF PARTICIPANT **DATE**

_____ _____

APPENDIX 2: INVITATION TO PARTICIPATE IN FOCUS GROUP

Dear

Invitation to attend a discussion on learning to recover from substance addiction through regular participation in an addiction aftercare support group.

My name is Margot Sennett Freedman, and I am registered for a PhD in Education at the University of KwaZulu-Natal. I am conducting a study on how addicts learn to recover through attendance of an addiction aftercare group, and would like to invite you to attend a discussion on this topic.

I am contacting you because you have been a member of this group and you have indicated that you are willing to take part in a focus group discussion with other xxxx group participants.

In the discussion I will ask you to share your experiences of being a member of an addiction support group and how this has assisted your recovery. My focus is on how you are learning to recover through participating in this group and how participating in the group maintains your recovery.

The focus group meeting should not be longer than 2 hours and refreshments will be provided.

The discussion will take place on…… at xxxx Clinic at …….pm.

Please let me know if you are able to attend this discussion by emailing me on sennett@ukzn.ac.za or confirm on 0835629789 or by telling me in person.

Many thanks.

Sincerely

Margot Sennett Freedman

Tel: 033 260 5734, 0835629789, Email: sennett@ukzn.ac.za

APPENDIX 3: INVITATION TO PARTICIPATE IN FOCUS GROUP

Dear

Invitation to attend a discussion on learning to recover from substance addiction through regular participation in an addiction aftercare support group.

My name is Margot Sennett Freedman, and I am registered for a PhD in Education at the University of KwaZulu-Natal. I am conducting a study on how addicts learn to recover through attendance of an addiction aftercare group, and would like to invite you to attend a discussion on this topic.

I am contacting you because you have been a member of this group and you have indicated that you are willing to take part in a focus group discussion with other xxxx group participants.

In the discussion I will ask you to share your experiences of being a member of an addiction support group and how this has assisted your recovery. My focus is on how you are learning to recover through participating in this group and how participating in the group maintains your recovery.

The focus group meeting should not be longer than 2 hours and refreshments will be provided.

The discussion will take place on…… at xxxx Clinic at …….pm.

Please let me know if you are able to attend this discussion by emailing me on sennett@ukzn.ac.za or confirm on 0835629789 or by telling me in person.

Many thanks.

Sincerely

Margot Sennett Freedman

Tel: 033 260 5734, 0835629789, Email: sennett@ukzn.ac.za

APPENDIX 4: INFORMED CONSENT – ADDICTION COUNSELLORS – RECOVERY GROUP FACILITATORS

Dear

Consent to participate in study on how addicts learn to recover through participating in an aftercare recovery group.

My name is Margot Sennett Freedman, and I am registered for a PhD in the School of Education at the University of KwaZulu-Natal (UKZN). I am conducting a study on how addicts learn to recover through participation in an addiction aftercare recovery group.

You have been a facilitator of the xxxxxx Addiction Aftercare group. I am therefore interested to include you as part of my study, focusing on how you teach addiction recovery.

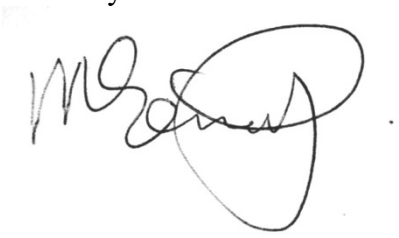
If you consent to participate in this study, your involvement will include attending at least one interview with me (approximately two hours, including refreshments), at xxxxx clinic. Any travel costs will be reimbursed by me.

The following points are important to note about this study:

- The activities we engage in will be audio-recorded and saved in electronic format. These audio-clips (and any transcriptions and documents that arise from these) will be securely kept by me for the duration of the study. I will then dispose of these five years after the study has been finalised.
- Any information you disclose will be kept confidential, and your identity will also remain anonymous.
- Your name (and any other identifying details) contained on any documents you produce or are produced during the data production process will be replaced with a code or pseudonym. I will be the only person who will be able to match the code or pseudonym back to you (the original data source).
- Involvement in this study will pose no harm, threat or financial cost to you. Should you need to travel anywhere for the study, these costs will be covered by the researcher.
- Your participation in this study is entirely voluntary, and you are free to withdraw your participation at any stage should you wish to.
- I anticipate that your involvement in the study could be of positive benefit to you. Specifically, your involvement could provide you with an opportunity to reflect upon the activities of your teaching and learning about recovery and how you would like to develop this in the future.

My research supervisor is Professor Wayne Hugo, and he can be contacted on hugow@ukzn.ac.za, or 033 260 5535 should you have any questions regarding the study, or your involvement in it.

Sincerely.



Margot Sennett Freedman

Tel: 033 260 5734, 083 562 9789 , Email: sennett@ukzn.ac.za

APPENDIX 5: CONSENT TO PARTICIPATE IN STUDY ON HOW ADDICTS LEARN TO RECOVER THROUGH PARTICIPATING IN AN AFTERCARE RECOVERY GROUP

ADDICTION COUNSELLOR CONSENT

Participant declaration

I…… (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.
Should you wish to be interviewed by a researcher other than the recovery group psychologist co-facilitator, please indicate below.
Consent to take part

I, _____ (full names of participant) confirm that I understand this consent form and the nature of the study and agree to take part in:

Consent	**Yes**	**No**	**Signature**
Interview (1–2 hours)			
Tape Recording Interview			
Interview with an anonymous researcher			

Date:

APPENDIX 6: FOCUS GROUP CONFIDENTIALITY CONTRACT

Your identity and responses will be known to other focus group research participants. Because of this, it is important that you respect the confidentiality of this research focus group by withholding the identities of participants and any information shared in the focus group.

This includes in the recovery group meeting unless it pertains specifically to your own recovery and is done without breaking confidentiality and identifying other participants.

Please will you sign below to indicate that you:

- agree to keep participants' identities confidential as well as all comments made during the focus group
- agree to not discuss what happened during the focus group outside the focus group meeting, unless it is with another participant of the focus group.

•Name and Signature if in agreement	
•	I have had my questions about confidentiality answered to my satisfaction.
•	I agree to maintain confidentiality of identity and information shared in this focus group.

Thank you.

APPENDIX 7: INVITATION TO ATTEND PRESENTATION

Dear

Invitation to attend presentation on study on how addicts learn to recover through participating in an aftercare recovery group and invitation to participate in study

My name is Margot Sennett Freedman, and I am registered for a PhD in the School of Education at the University of KwaZulu-Natal (UKZN). I am conducting a study on how addicts learn to recover through participation in an addiction aftercare recovery group.

You have been a participant in the XXXXX Aftercare group. I would therefore like to invite you to participate in this study. I will be having a short (30 minute) presentation on……..where I will explain the study goals and methods.

Those attending the presentation will be given the opportunity to ask any questions regarding the study. You are invited to this presentation but your attendance there doesn't mean to have to consent to be in the study.

For your information, the study methods include:

- one individual interview with me (approximately two hours in total).
- focus group discussion, with other group members, where the role of the aftercare group in your recovery and your learning to recover will be discussed (approximately two hours). Refreshments will be served.

These activities will take place at XXXXX Clinic at mutually convenient times.

Please could you confirm whether you are interested in attending the presentation.

Thank you

Kind regards

Margot Sennett Freedman

083 562 9789

Sennett@ukzn.ac.za

Dear Margot

I will/won't (please circle the option that applies)

be attending the presentation on the research on how addicts learn to recover in an addiction recovery group

I am still interested in hearing more about the study:

I would like to hear more about the:

- Individual interview YES/NO (Please circle the option that applies)
- Focus group YES/NO (Please circle the option that applies)

My name is:

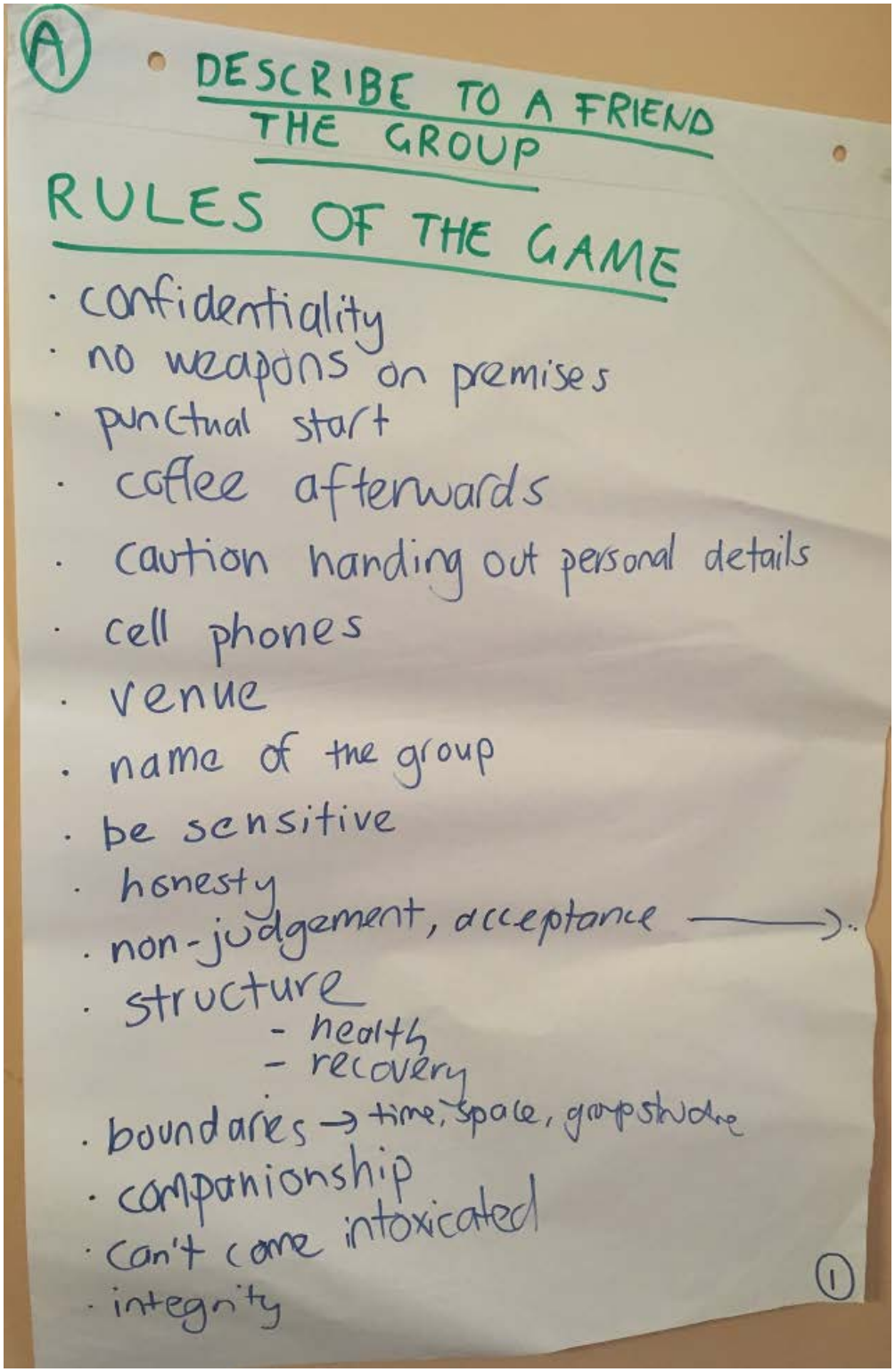
Signature

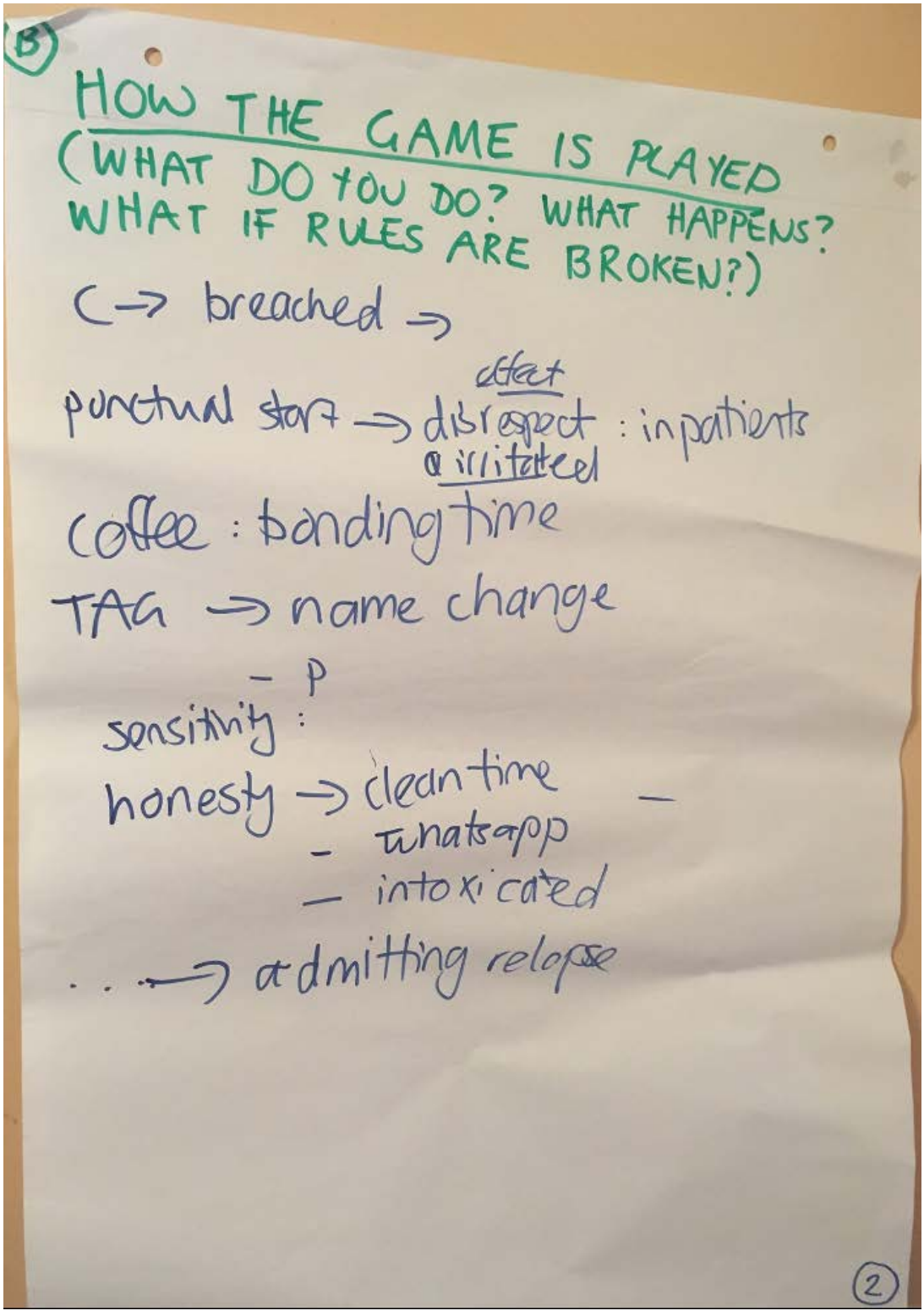
Cell number

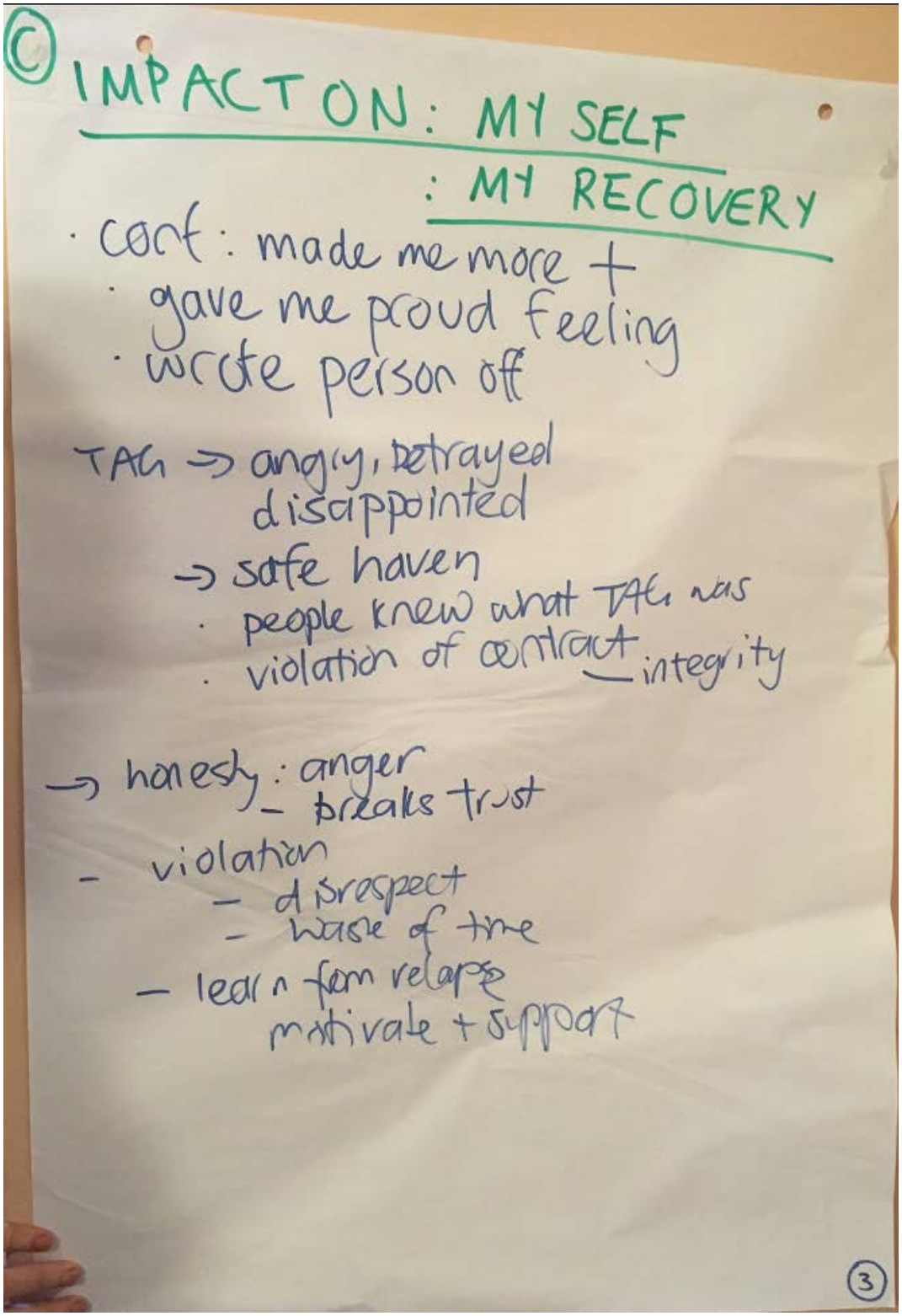
Email address:

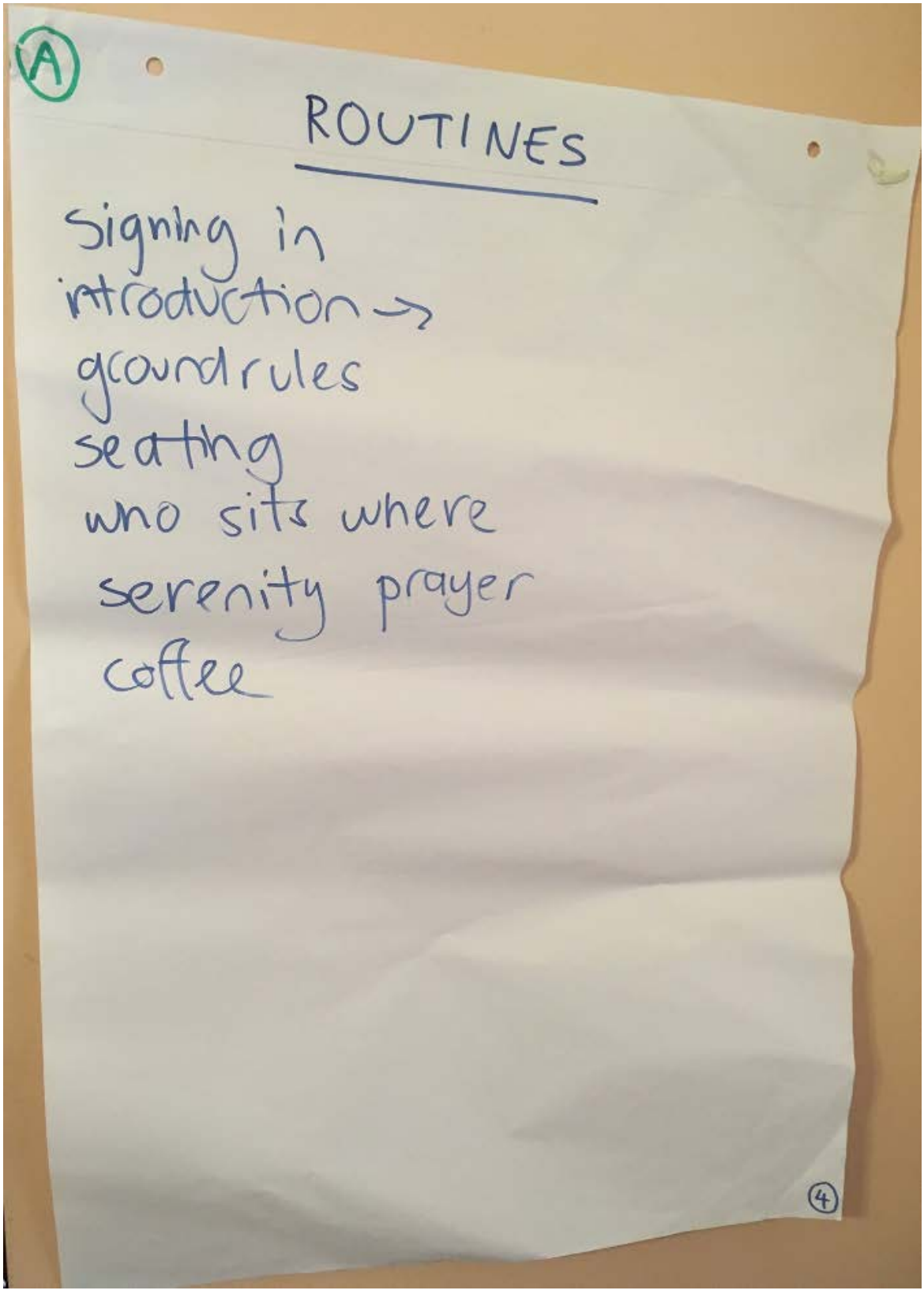
APPENDIX 8: NOTES FROM FOCUS GROUPS

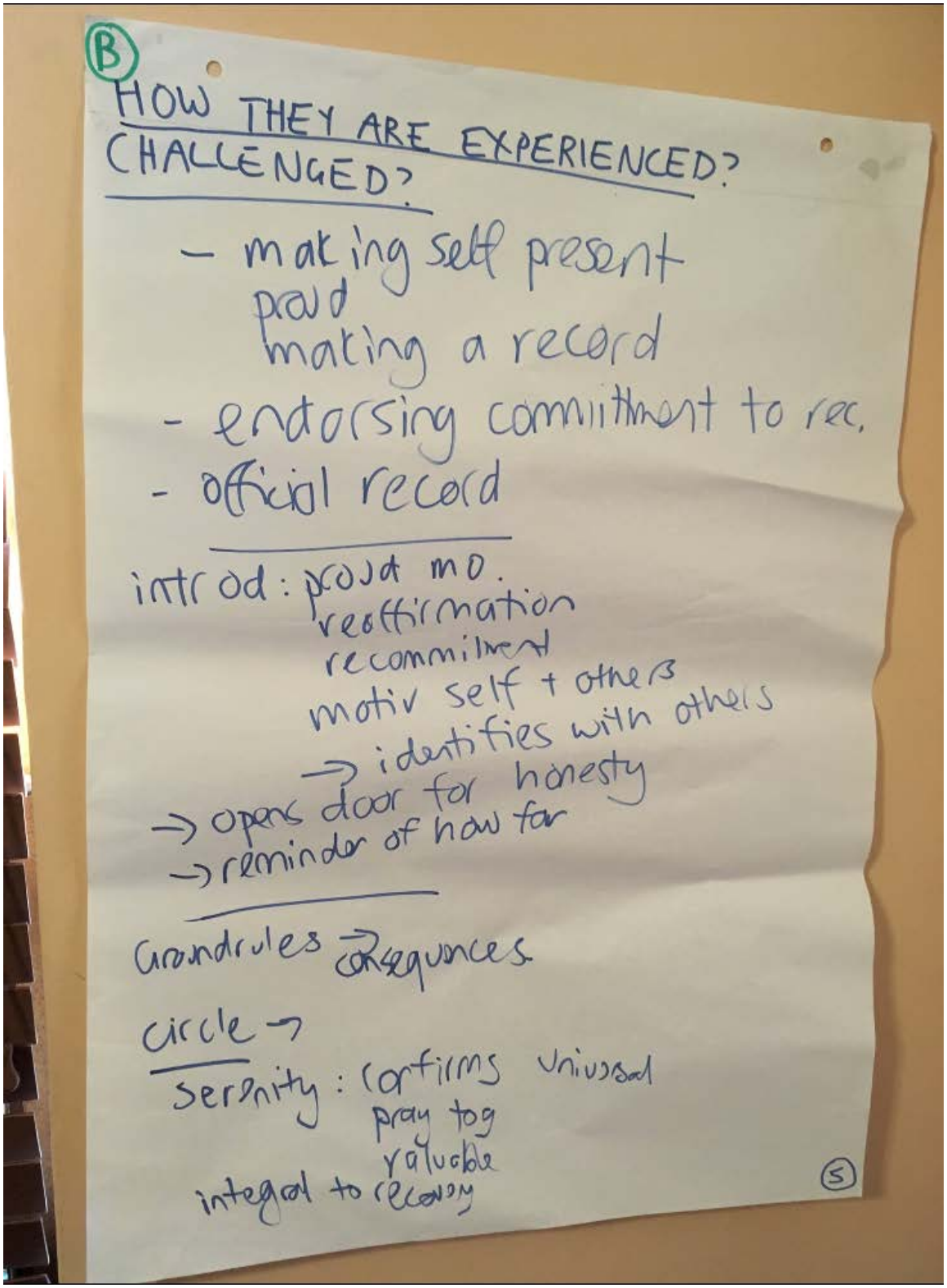
16 June 2016, 25 June 2016, 17 July 2016, 1 October 2016 and 11 November 2017.

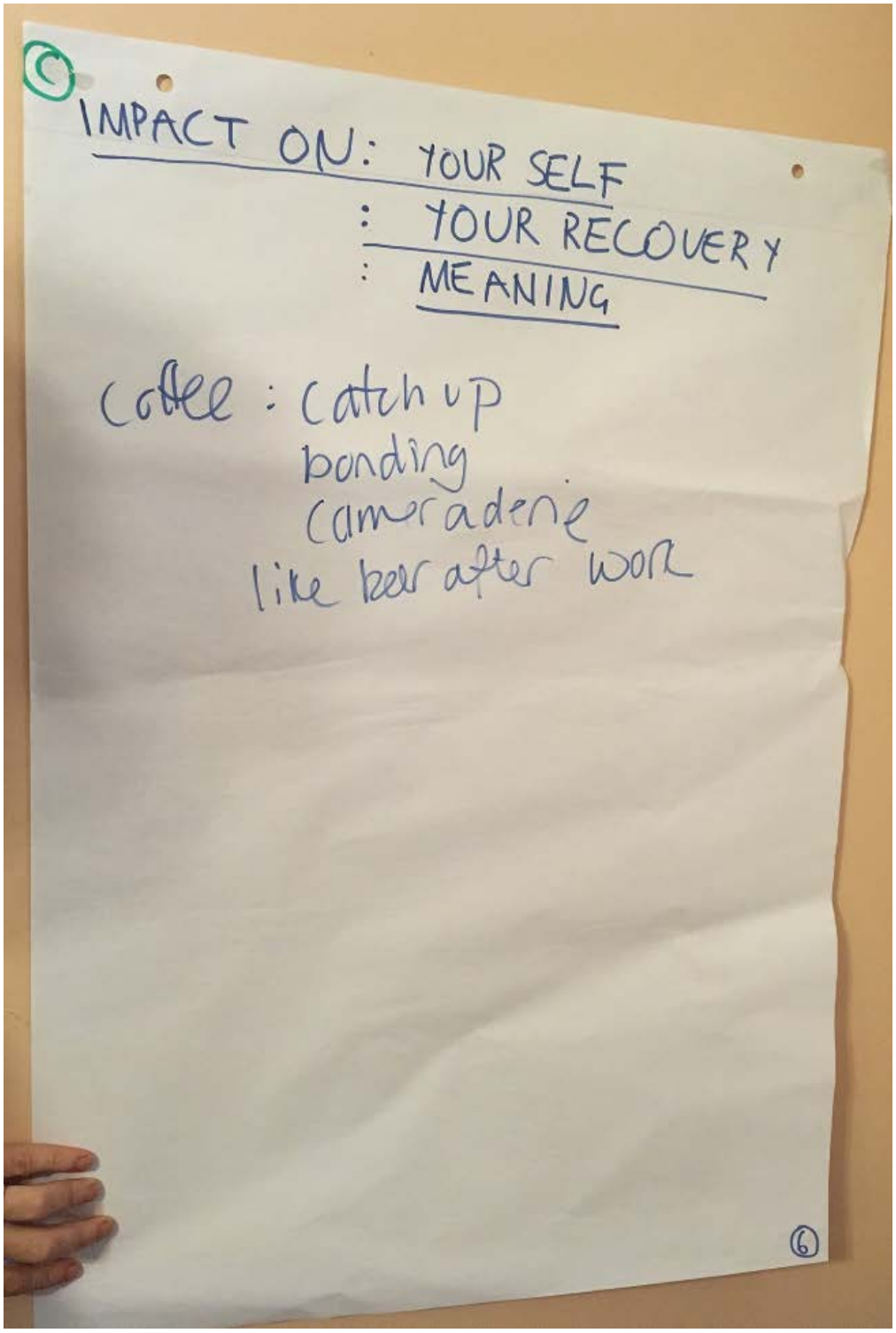


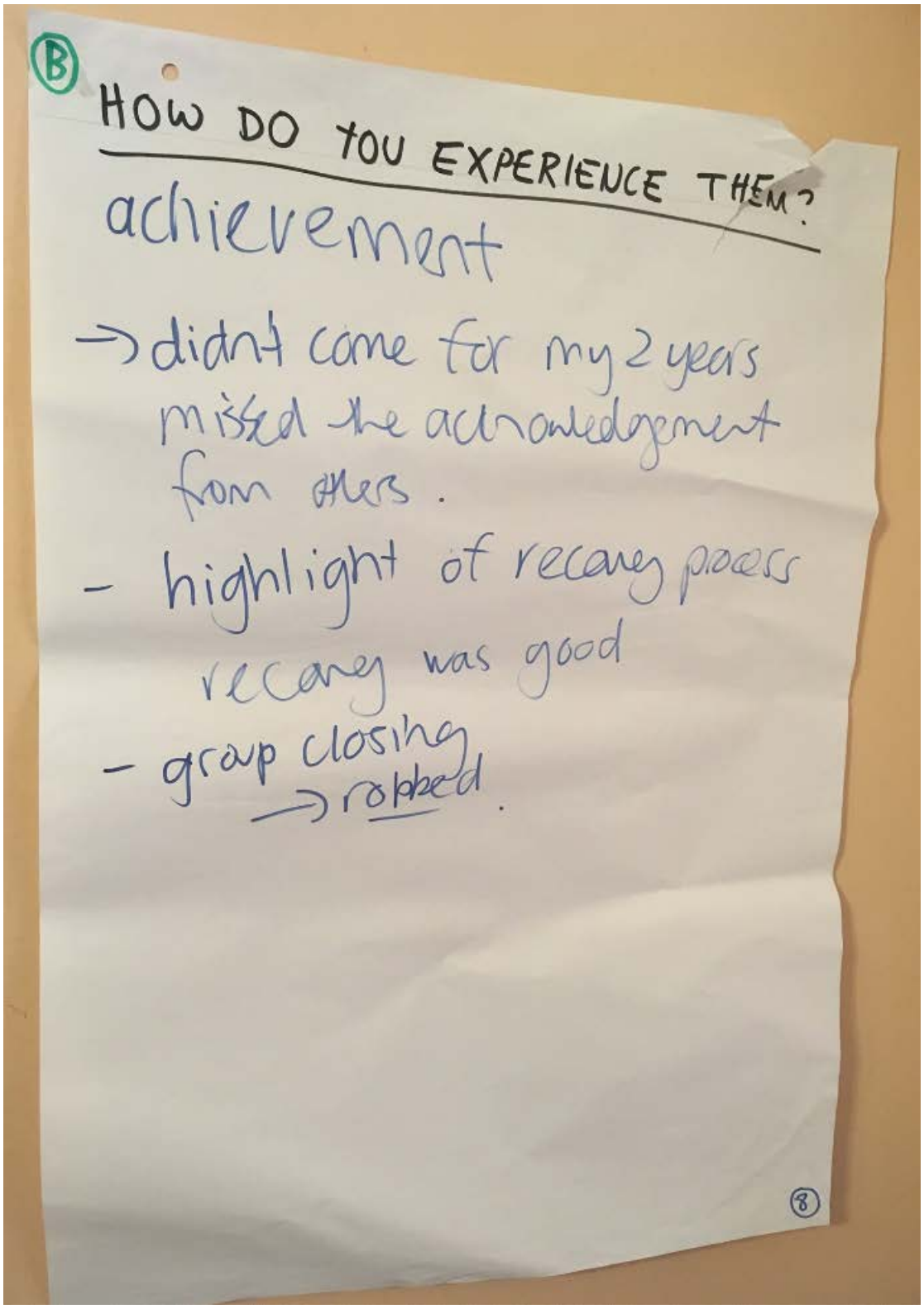

B
HOW THE GAME IS PLAYED
(WHAT DO YOU DO? WHAT HAPPENS?
WHAT IF RULES ARE BROKEN?)
breached
punctual start → disrespect : inpatients
irritated
coffee : banding time
TAG → name change
- P
sensitivity :
honesty → clean time
- whatsapp
- intoxicated
→ admitting relapse
2

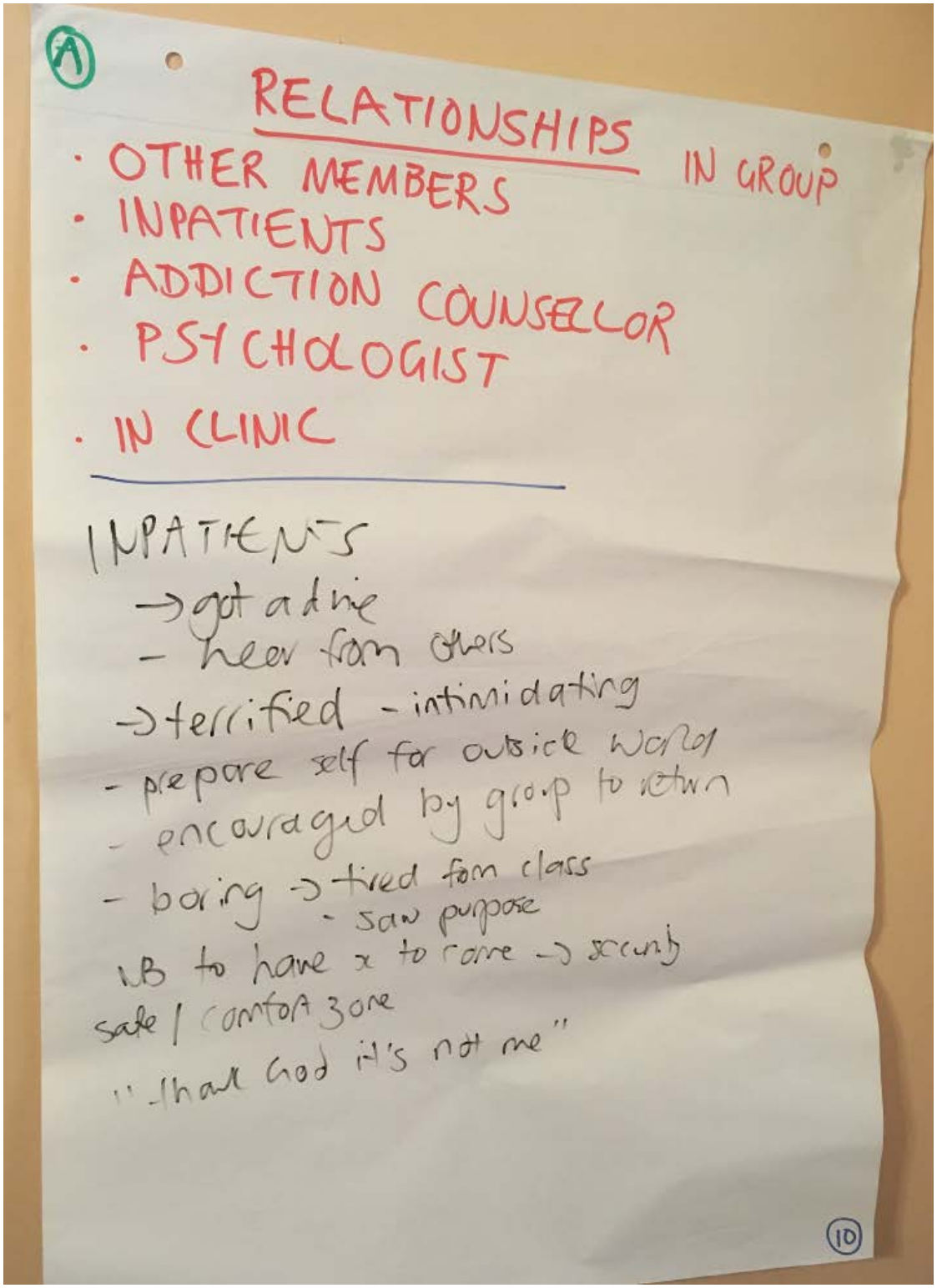

IMPACT ON: MY SELF
: MY RECOVERY
· conf: made me more +
· gave me proud feeling
· wrote person off
TAC → angry, betrayed
disappointed
→ safe haven
· people knew what TAC was
· violation of contract integrity
→ honesty: anger
- breaks trust
- violation
- disrespect
- waste of time
- learn from relapse
motivate + support
3

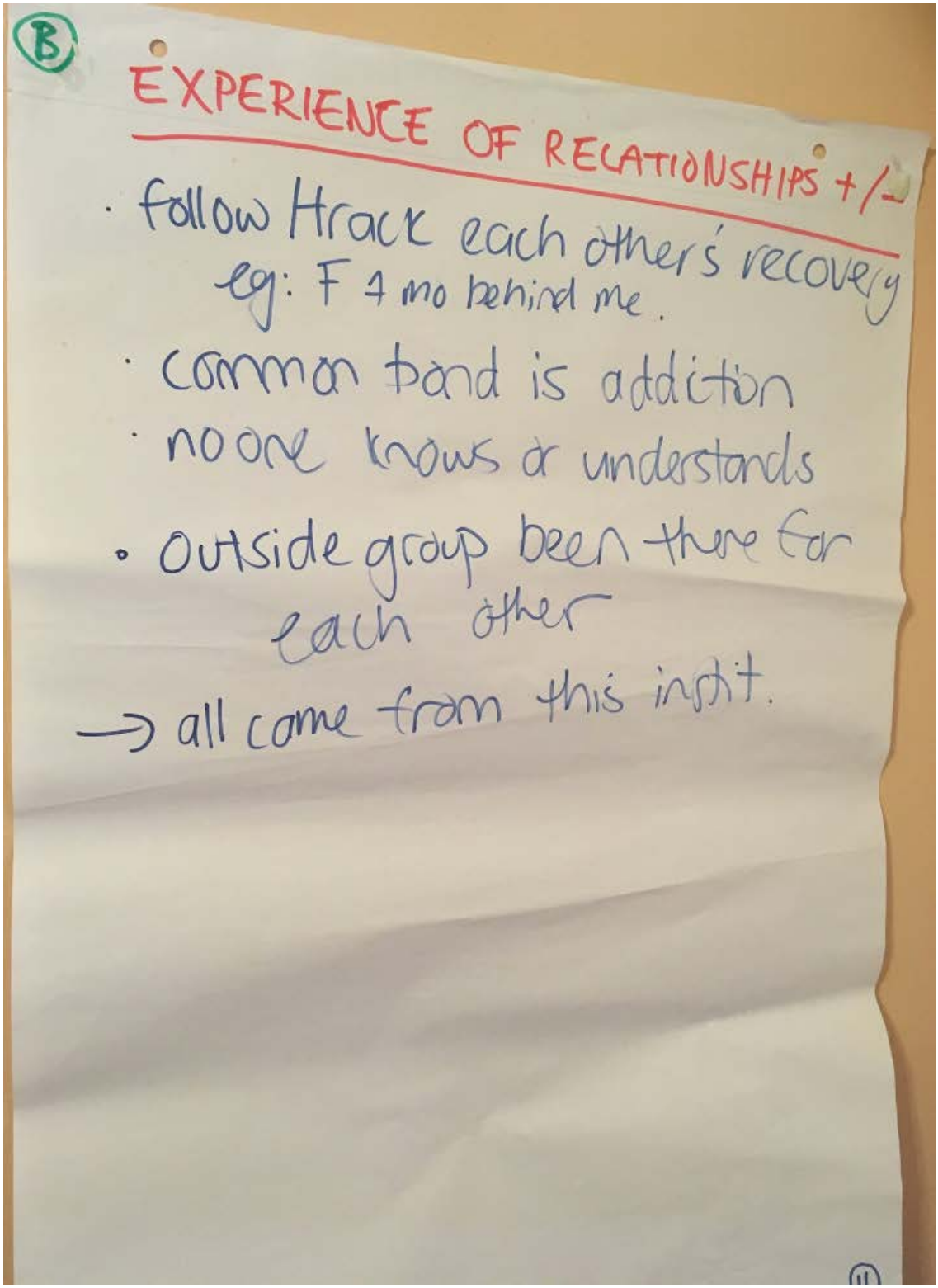

A
ROUTINES
signing in
introduction →
ground rules
seating
who sits where
serenity prayer
coffee
4

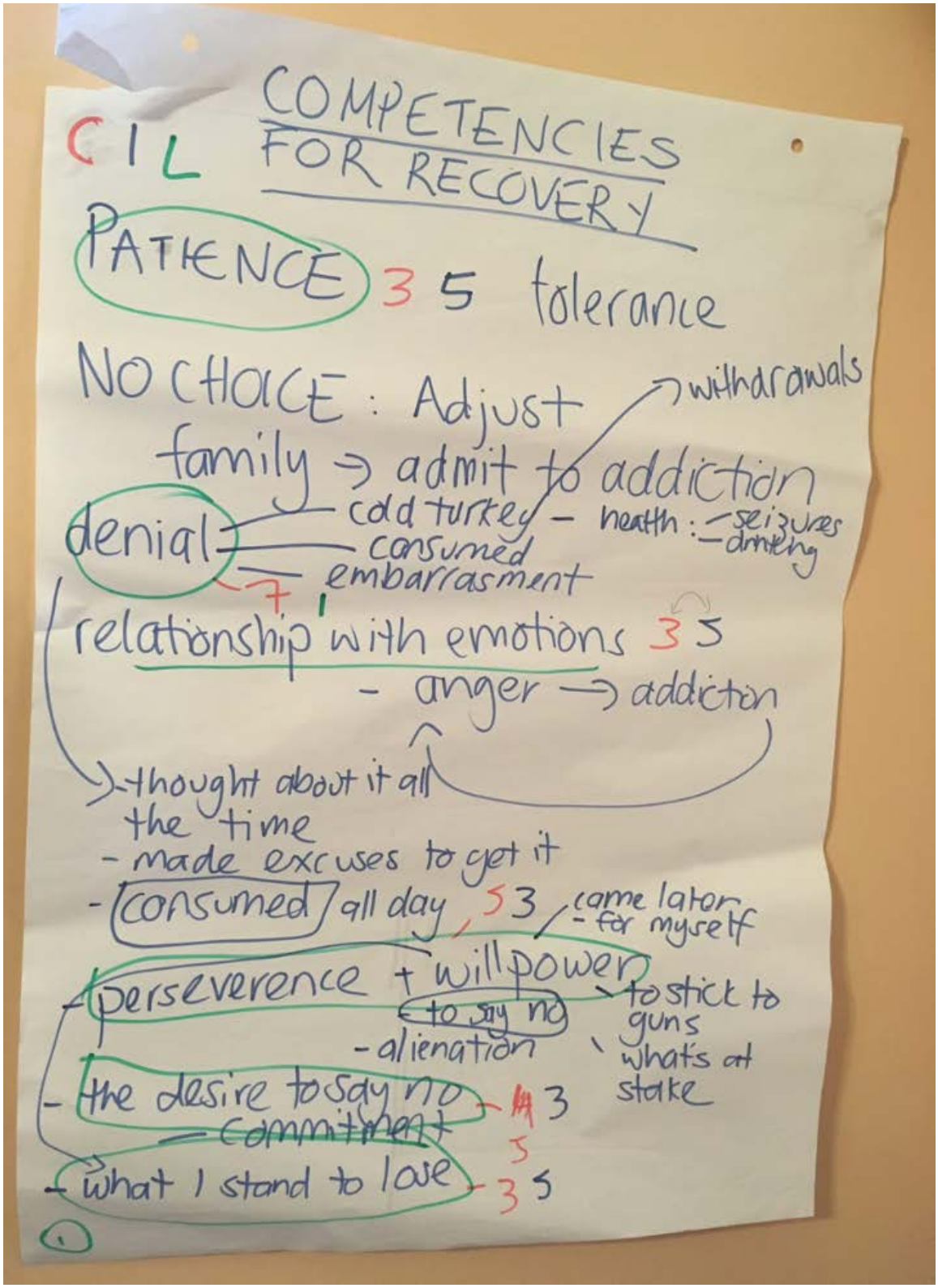

B
HOW THEY ARE EXPERIENCED? CHALLENGED?
- making self present
prayd
making a record
- endorsing commitment to rec.
- official record
introd: prayd mo.
reaffirmation
recommitment
motiv self + others
→ identifies with others
→ opens door for honesty
→ reminder of how far
Groundrules → consequences
circle →
Serenity: confirms Universal
pray tog
valuable
integral to recovery
5

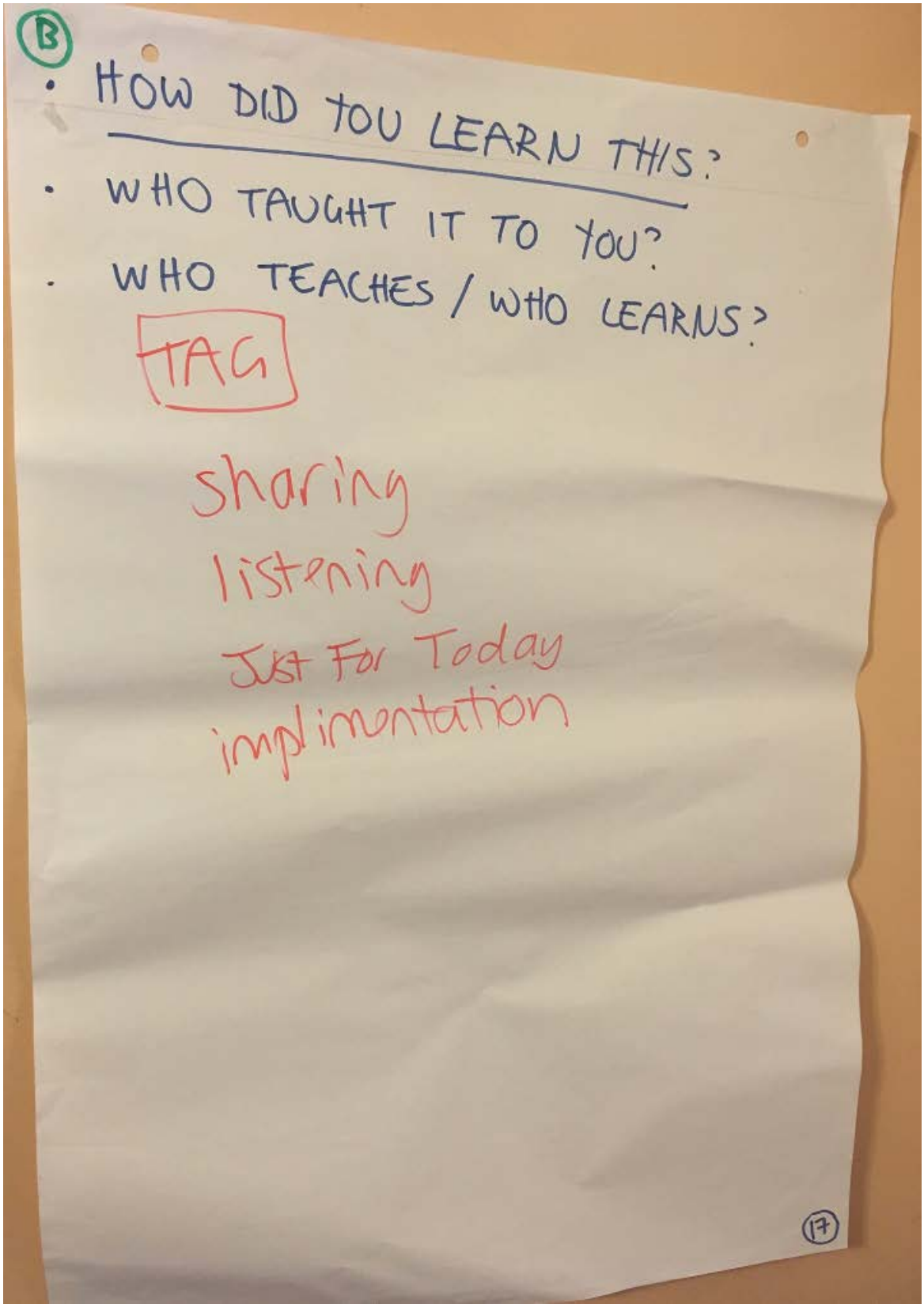

IMPACT ON: YOUR SELF
: YOUR RECOVERY
: MEANING
coffee : catch up
bonding
camaraderie
like beer after work
6

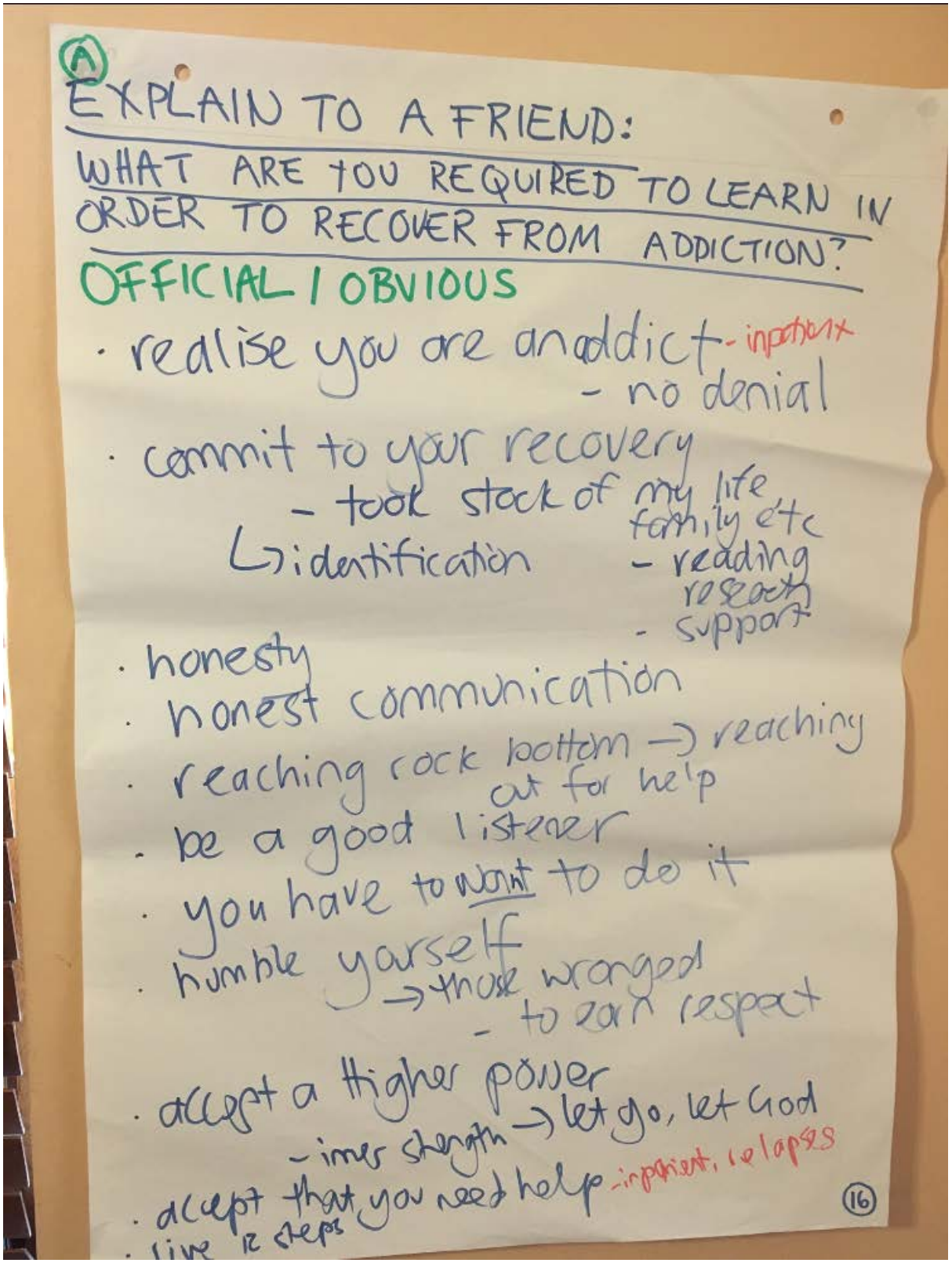

B
HOW DO YOU EXPERIENCE THEM?
achievement
→ didn't come for my 2 years
missed the acknowledgement
from others.
- highlight of recovery process
recovery was good
- group closing
→ robbed.
8

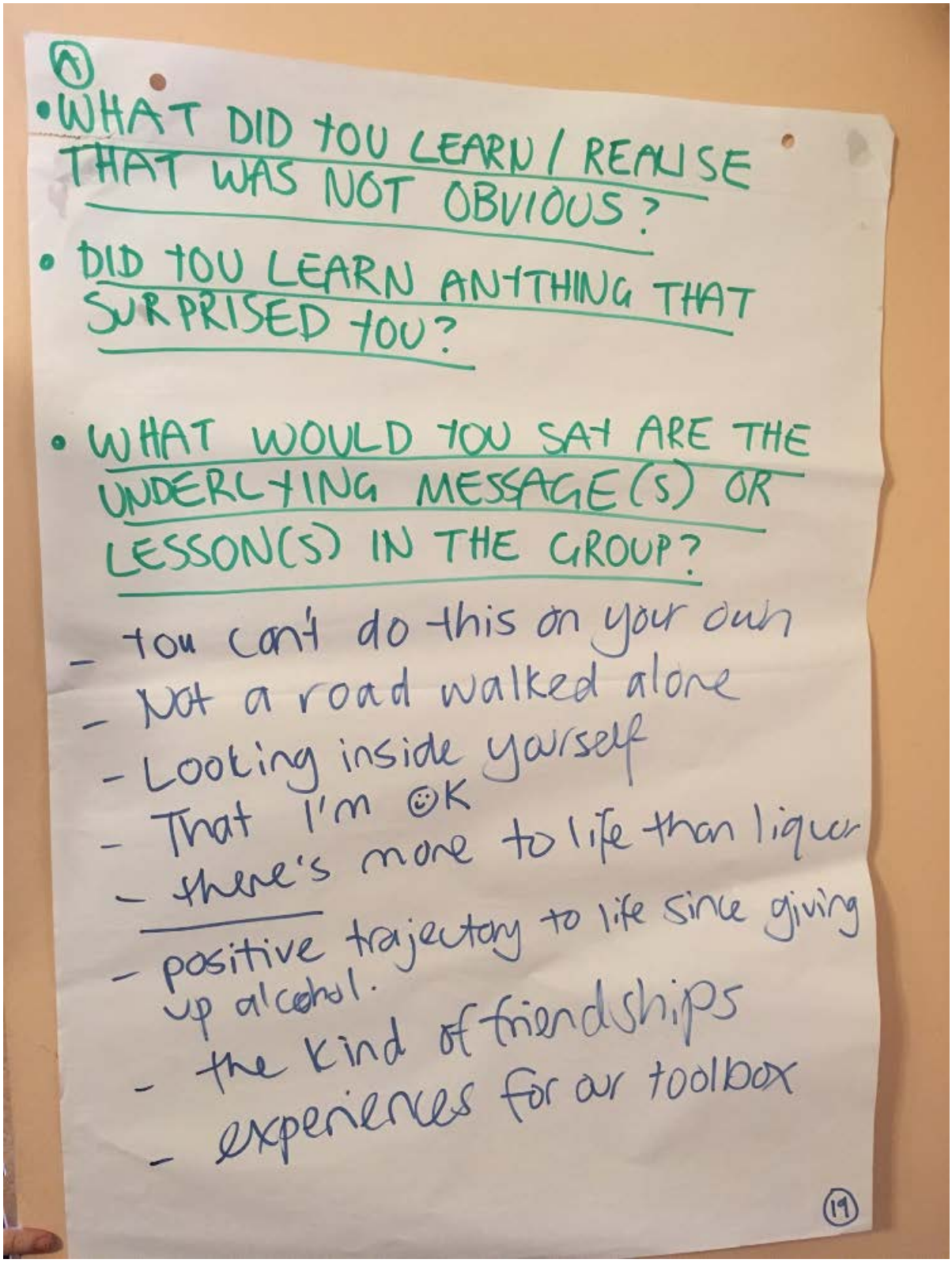

A
RELATIONSHIPS IN GROUP
· OTHER MEMBERS
· INPATIENTS
· ADDICTION COUNSELLOR
· PSYCHOLOGIST
· IN CLINIC
INPATIENTS
→ got advice
- hear from others
→ terrified - intimidating
- prepare self for outside world
- encouraged by group to return
- boring → tired from class
- saw purpose
NB to have x to come → scary
safe / comfort zone
"Thank God it's not me"
10

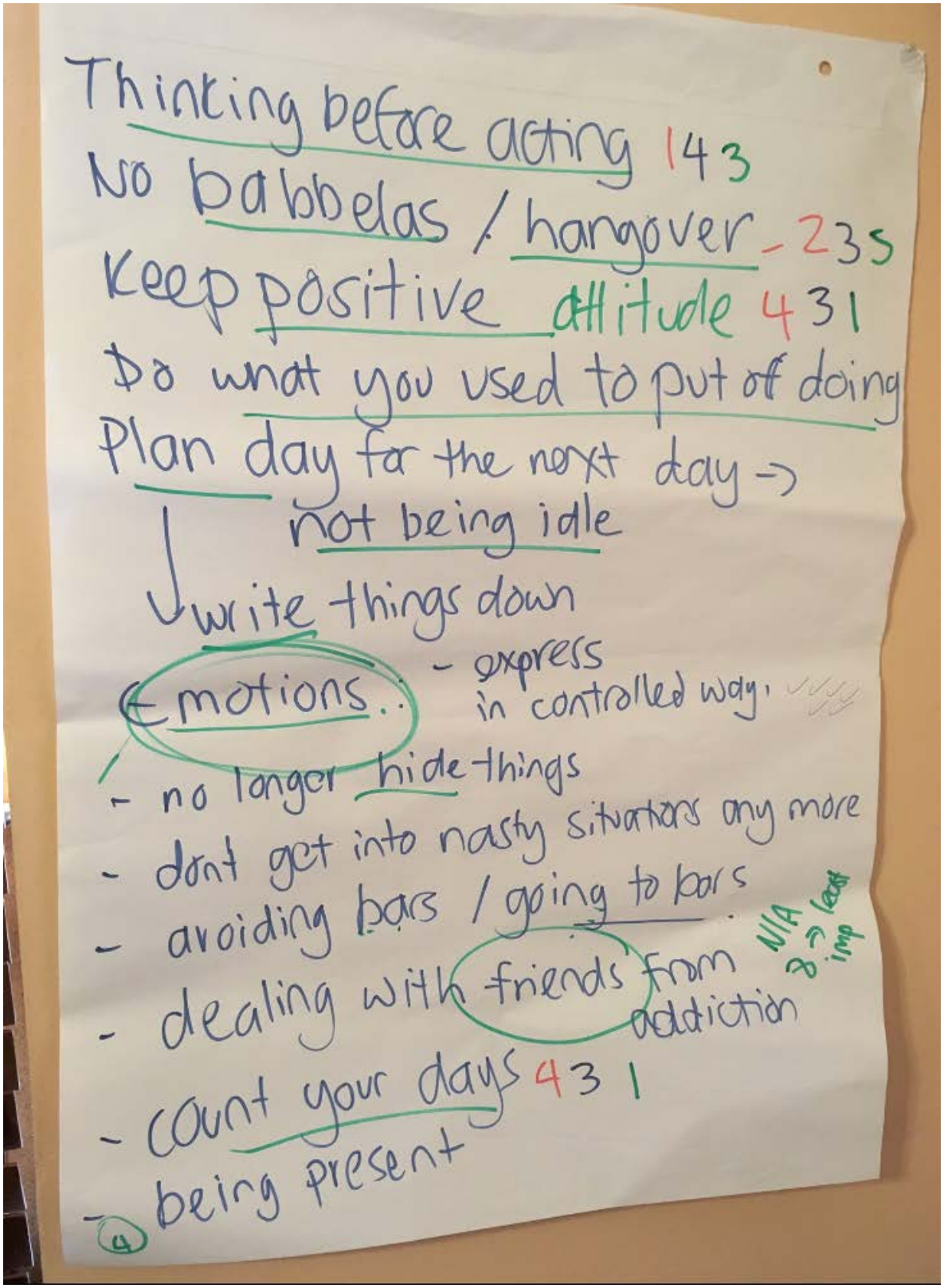

B
EXPERIENCE OF RELATIONSHIPS +/-
· follow track each other's recovery
eg: F 4 mo behind me.
· common bond is addiction
· no one knows or understands
· outside group been there for each other
→ all come from this instit.

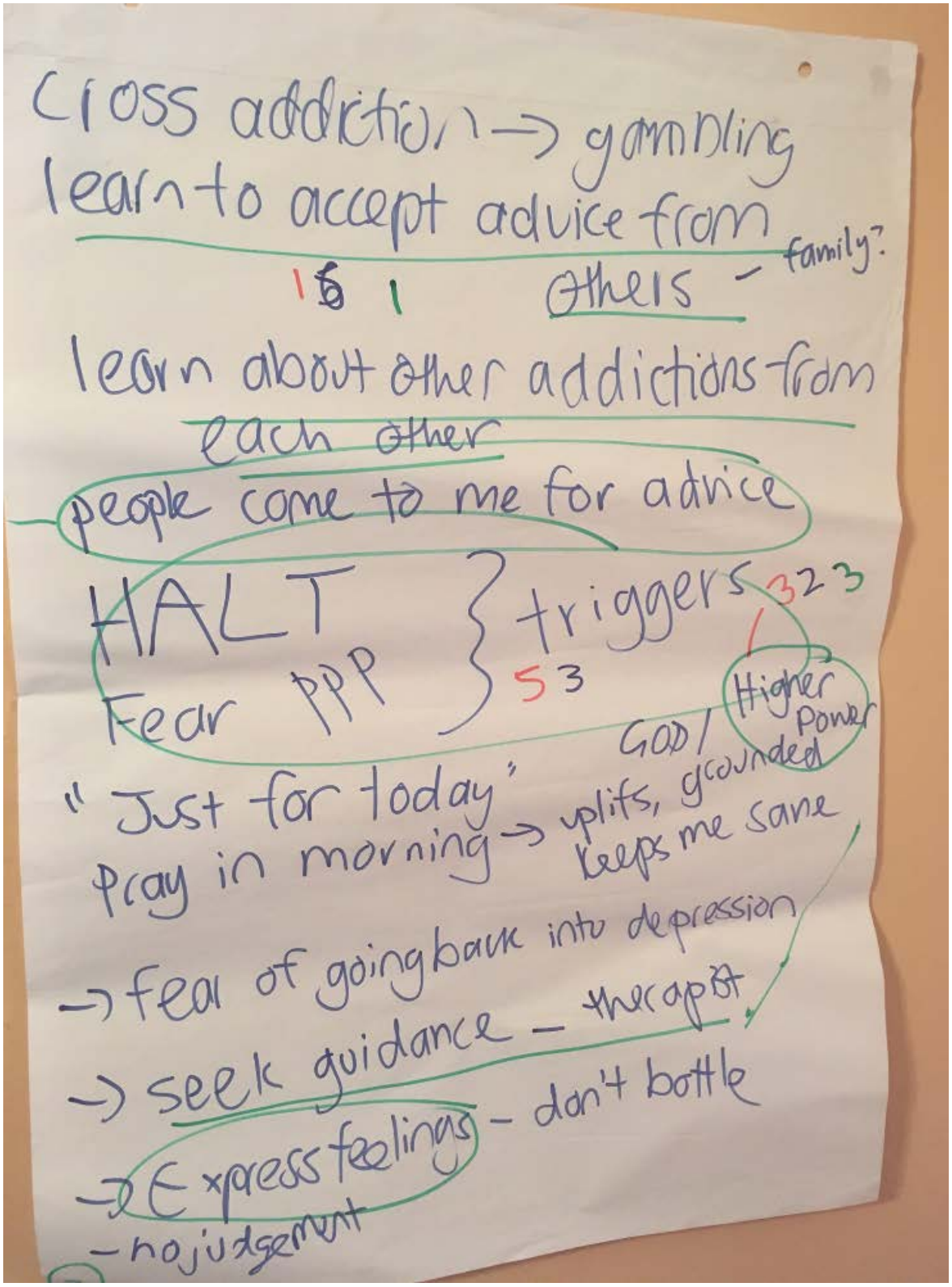

CIL COMPETENCIES FOR RECOVERY
PATIENCE 3 5 tolerance
NO CHOICE: Adjust → withdrawals
family → admit to addiction
denial
cold turkey - health: - seizures - drinking
consumed
embarrasment
7
relationship with emotions 3 5
- anger → addiction
thought about it all the time
- made excuses to get it
- consumed all day 5 3 came later - for myself
perseverence + willpower → to stick to guns
to say no
- alienation
what's at stake
- the desire to say no 3
commitment
5
- what I stand to lose 3 5

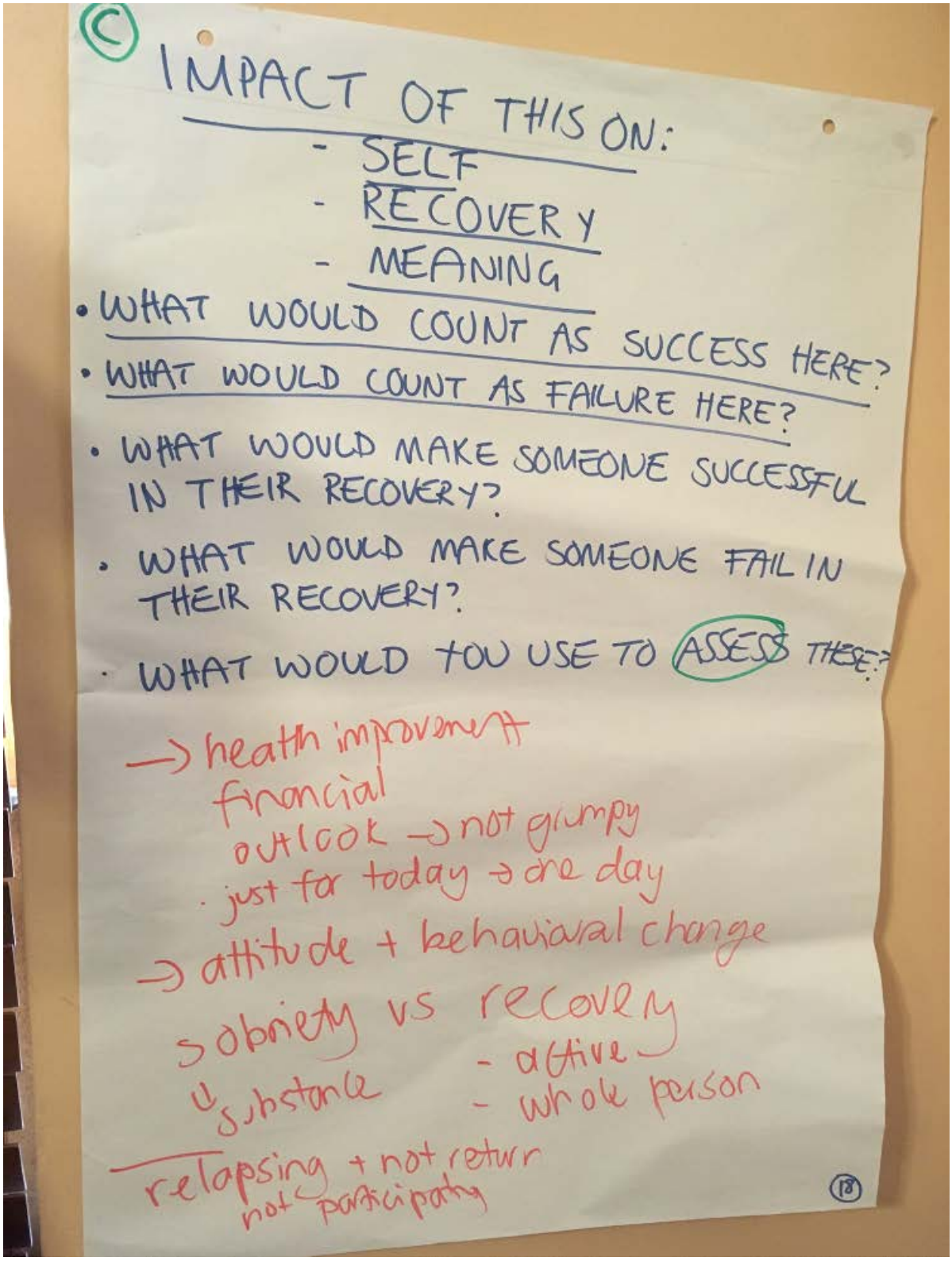

B
HOW DID YOU LEARN THIS?
WHO TAUGHT IT TO YOU?
WHO TEACHES / WHO LEARNS?
TAG
sharing
listening
Just For Today
implimentation
17

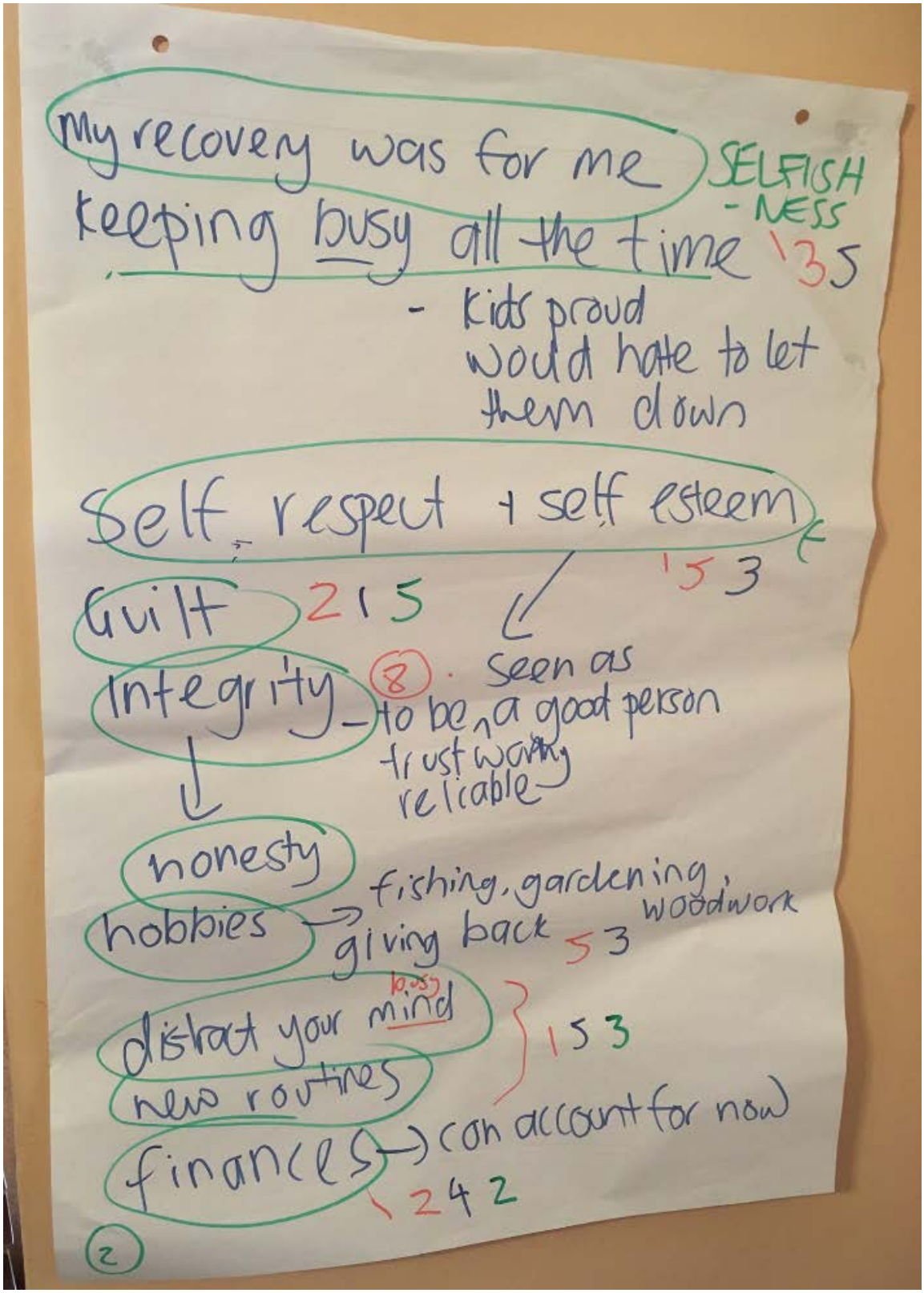

A
EXPLAIN TO A FRIEND:
WHAT ARE YOU REQUIRED TO LEARN IN ORDER TO RECOVER FROM ADDICTION?
OFFICIAL / OBVIOUS
· realise you are an addict - impotent
- no denial
· commit to your recovery
- took stock of my life, family etc
↳ identification
- reading research
- support
· honesty
· honest communication
· reaching rock bottom → reaching out for help
· be a good listener
· you have to want to do it
· humble yourself
→ those wronged
- to earn respect
· accept a higher power
- inner strength → let go, let God
· accept that you need help - impotent, relapses
· live 12 steps
16


(A)
• WHAT DID YOU LEARN / REALISE THAT WAS NOT OBVIOUS?
• DID YOU LEARN ANYTHING THAT SURPRISED YOU?
• WHAT WOULD YOU SAY ARE THE UNDERLYING MESSAGE(S) OR LESSON(S) IN THE GROUP?
- You can't do this on your own
- Not a road walked alone
- Looking inside yourself
- That I'm ☺K
- there's more to life than liquor
- positive trajectory to life since giving up alcohol.
- the kind of friendships
- experiences for our toolbox
(19)


Thinking before acting 143
No babbelas / hangover - 235
Keep positive attitude 431
Do what you used to put off doing
Plan day for the next day ->
not being idle
write things down
emotions..
- express in controlled way.
- no longer hide things
- dont get into nasty situations any more
- avoiding bars / going to bars
- dealing with friends from addiction
N/A 2 => least imp
- count your days 431
- being present
4


Cross addiction → gambling
learn to accept advice from
others - family?
learn about other addictions from
each other
people come to me for advice
HALT
Fear PPP
triggers 3 2 3
5 3
Higher Power
God/
"Just for today"
pray in morning → uplifs, grounded
keeps me sane
→ fear of going back into depression
→ seek guidance - therapy
→ Express feelings - don't bottle
- no judgement


C
IMPACT OF THIS ON:
- SELF
- RECOVERY
- MEANING
• WHAT WOULD COUNT AS SUCCESS HERE?
• WHAT WOULD COUNT AS FAILURE HERE?
• WHAT WOULD MAKE SOMEONE SUCCESSFUL IN THEIR RECOVERY?
• WHAT WOULD MAKE SOMEONE FAIL IN THEIR RECOVERY?
• WHAT WOULD YOU USE TO ASSESS THESE?
→ health improvement
financial
outlook → not grumpy
just for today → one day
→ attitude + behavioral change
sobriety vs recovery
↓ substance
- active
- whole person
relapsing + not return
not participating
18


My recovery was for me
SELFISH - NESS
keeping busy all the time
135
- kids proud would hate to let them down
self respect + self esteem
153
Guilt
215
Integrity
8. seen as to be a good person trust worthy reliable
honesty
hobbies
fishing, gardening, woodwork
giving back
53
distract your mind
busy
new routines
153
finances
can account for now
242
2

APPENDIX 9: EMERGENT THEMES FROM TRANSCRIBED INDIVIDUAL INTERVIEWS

Relearning responses to Emotions (difficult emotions?)

Dismantling shame

Rejecting self?

Anger

Self Worth/Self esteem

A place to build recovery by being honest (p28)

A Place to learn about processing emotion (P39)

Building self-esteem, self

Dynamics of the Group Facilitative of Recovery

The Group as A Place to Release In

The group as a place to compare oneself to others

The group as a place to build recovery by motivating others

Role of The Inpatients in Group Addiction Recovery (p24) (huge motivator – links to CoP newcomers)

A place to build recovery by being motivated by others (p30)

The group as a place to be really understood

The group as a place to belong (CoP – membership and joint enterprise)

Group as a Place to Build Recovery by Learning How to Cope with Life (p32)

Group as A Place to build recovery by learning to living better (p34)

A Place to Build Identity and Find Myself (p35) and p38 – recovery is unique to the individual

Teaching and Learning:

Giving Feedback in The Group (p40)

Role of the Addiction Counsellor

Role of the psychologist

Why this group? (Membership – CoP) p17

Transmission of Knowledge (P57)

3. Knowledge

Why this group? (Membership – CoP)

Group as a Place to Build Recovery by Learning About Recovery (p38)

Assessment – checking in with days ,how people feel if lies are told about days – recovering honest days (p48) (curriculum?)
Knowledge needed in early recovery (p50)
Knowledge needed in later recovery (P54)
Knowing your triggers for relapse (p56)

Additional Knowledge
Staying accountable

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PROFESSIONAL EDITING

I, Barbara L. Louton, do hereby declare that I am a professional editor with a Bachelor of Arts in Professional Writing and fourteen years of experience as an editor, researcher and writer.

I declare that I was contracted by Margot Jane Sennett Freedman (Student number: 214583276), a PhD candidate under the supervision of Prof. Wayne Hugo in the School of Education at the University of KwaZulu-Natal, to complete a professional edit of her thesis:

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I declare that I have completed a two-phase professional edit of the document. The first edit addressed the clear and logical presentation and articulation of ideas by proposing structural and language changes through tracked changes and comments. After the client responded to the first edit, the second edit addressed the technical accuracy of the language in the document as well as formatting and layout.

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I can be contacted at:

Cell: 073 766 1139

Email: bellway@gmail.com

Barbara L Louton		10 November 2019
Name	Signed	Date